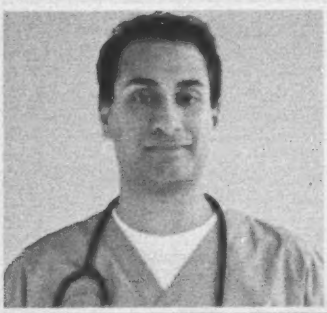
BRITISH COLUMBIA

Patient Care Quality Review Boards



Annual Report 2013/2014

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Letter to the Minister of Health

September 11, 2014

The Honourable Terry Lake
Minister of Health
Room 337, Parliament Buildings
Victoria, BC V8V 1X4

Dear Minister:

It is our pleasure to present the Patient Care Quality Review Boards' Annual Report for the period from April 1, 2013 to March 31, 2014. This report has been prepared in accordance with sections 15(1) and 16(1) of the *Patient Care Quality Review Board Act*.

We want to thank our secretariat staff for their ongoing good work and support which helped to make this year a success. We would also like to acknowledge the dedication of the health care professionals who deliver quality health care and recognize the commitment of the health authorities to improving patient care quality in British Columbia. We thank patients, clients, residents, and their loved ones for bringing their personal health care experiences to us which sparks quality improvement in our health care system.

Respectfully submitted,

Dr. John (Jack) H. Chritchley
chair, Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards

Roger Sharman
chair, Interior Patient Care Quality Review Board

William Norton
chair, Northern Patient Care Quality Review Board

Richard J. Swift, Q.C.
chair, Vancouver Island Patient Care Quality Review Board

Patient Care Quality Office

"The Patient Care Quality Review Boards are driven by their understanding that a high quality health care system succeeds by making the patient and the patient's needs the focus of decisions regarding system change."

DR. JOHN (JACK) H. CHRITCHLEY
chair, Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards

Introduction

The Patient Care Quality Review Boards are a fundamental part of a program that focuses on individual care quality experiences within our health system and translates those experiences into quality improvements. The program replicates and improves upon international best practices for reviewing patient care quality complaints.

The Patient Care Quality Review Boards were established by the *Patient Care Quality Review Board Act*. There are six boards – each one aligned with a health authority. The boards are independent from the health authorities and accountable to the Minister of Health.

The boards operate under the supposition that most individual complaints received are indicative of a concern that others have experienced, but not raised. In these cases, the boards see complaints as opportunities – opportunities that may result in recommendations to either the individual health authorities or to the Minister of Health to improve systems, processes, policies or services for the benefit of all British Columbians.

The boards focus on reviewing complaints that have not been resolved at the health authority level and believe in patient-centred care as the foundational driver in the planning and implementation of all strategic actions in the health system strategy. The boards are well positioned to align with the Ministry of Health's goal to deliver patient-centered health care – a service built around the individual, not the provider and administration.

The board members are provided with a complete picture of a patient's care experience from start to finish, including the investigation and proposed resolution by the health authority Patient Care Quality Office. This start-to-finish assessment of the care experience enables the boards to identify lapses in communication, care quality and complaint resolution, which may not have been evident to others in the health care system.

The Patient Care Quality Review Boards' annual report provides a unique view of the care quality and improvement opportunities in British Columbia.

Executive Summary

In 2013/14, the boards accepted 105 review requests. This represents a 17 per cent increase over the highest previous annual intake for the boards, achieved in 2011/12. The boards completed 75 reviews and made 83 recommendations to the health authorities for care quality improvement. In 24 of the cases, the boards did not make recommendations because either the care quality provided was reasonable or the circumstances of the complaint did not present an opportunity for care quality improvement. Some of the lessons learned from the boards' recommendations are also being shared across the health authorities.

This year, the key themes of the boards' recommendations to the health authorities centred on communication, home and community care services, and care quality. The boards also made one recommendation to the Minister of Health this year to review the Home Oxygen program and ensure home and community care palliative patients are fully informed about subsidized home oxygen and its application process so they may apply for and receive all eligible subsidies in a timely manner.

Since the program's inception in 2008, the boards have completed 360 reviews and made a total of 505 recommendations to the health authorities, prompting action on a broad range of care quality issues. In that time, the boards have also made nine recommendations to the Minister of Health, including: reviewing the care model for children with cerebral palsy; housekeeping inspection in hospitals; inter-facility ambulance transfers; patient fees for non-residents; the method for informing British Columbians of the choices in supports for independent living processes; a review of BC Children's Hospital waitlist management; and the process for supervision of student medical radiation technologists.

As part of their mandate, the health authority Patient Care Quality Offices (PCQOs) collect data regarding the number and type of external complaints, care quality complaints, and inquiries such as requests for information. This data is then reported to the boards quarterly. The PCQOs received 8,454 complaints and inquiries this year, which was nearly unchanged from the 8,443 received the previous year. Of these, 6,473 were care quality complaints, which the PCQOs reviewed. The boards accepted 105 review requests during the fiscal year, approximately two per cent of the total care quality complaints received by the health authorities.

Similarly, the boards track data about the types and number of client exchanges it directly receives. In total, the boards received 992 client enquiries relating to a broad range of care quality issues. This includes all other inquiries (by telephone, fax, email or letter) in addition to the formal review requests.

The boards continue to implement the findings and recommendations from the program evaluation conducted in 2012/13. These improvements represent an important opportunity to ensure the program continues to operate based on a clearly defined mandate that continues to support a complaints management process for British Columbians that is accessible, clear, consistent, timely and transparent.

The Patient Care Quality Review Board members from across the province meet annually to discuss best practices for reviewing complaints, share experiences and lessons learned over the year. These meetings also present an opportunity for learning about new innovations in the health care system relevant to the complaints that come to the boards for review.

"Working from the patient's perspective on the full lifecycle of care provided, the Patient Care Quality Review Boards are able to make recommendations that can focus on any aspect of the performance of health care, ranging from a small unit to a large region or even to influence care patterns provincewide."

WILLIAM NORTON
chair, Northern Patient Care Quality Review Board

Care Quality Improvements and Board Achievements

The Patient Care Quality Review Boards' recommendations to the health authorities are based on the boards' review of the facts about the case presented to them.

Once a recommendation is received, the health authority is required to respond with its plan to address the recommendation or to indicate whether work is already underway to address the recommendation. The health authorities' responses to the boards' recommendations have the potential to lead to better outcomes and care quality improvement in the health care system.

Under the theme of communication, board recommendations aimed at closing these communication gaps ranged from health care practitioners ensuring that family concerns be recorded in the patient's chart, to arranging in person meetings and/or follow-up investigations to ensure the patients, clients, residents and/or their families have a better understanding of what occurred.

The boards would also like to take this opportunity to announce the launch of the Online Review Request form. The boards are the first public bodies in the province to offer a service of this nature, featuring an electronic signature to obtain consent from the complainant to initiate a review. This marks the culmination of a significant amount of work in order to provide a secure and user-friendly method for the submission of complaints.

Additionally, the boards reached another milestone this year, completing their 300th review. While that total proceeded to grow to 360 by the end of the fiscal year, it is further evidence that the boards have provided a valuable avenue for patients, clients, residents and their families to raise complaints about their health care. Private individuals do have the opportunity to effect change and improve the system. Building upon the patient experience, the boards have contributed to significant positive change and improvement in our health care system and the boards take this opportunity to thank all those who made the effort and took the time to raise their concerns so that improvements could be made.

The boards would like to take the opportunity to acknowledge the work of the Patient Care Quality Offices and its officers. The boards have noted that the health authorities' response letters provided to complainants are offering a clear outline of the complaints received and complete responses to each concern.

Key Recommendation Themes in 2013/14

Communication

As has been noted, communication issues are a recurring theme in every health authority and this is reflected in many recommendations. Communication issues can arise at any level of care and in every care setting. The boards acknowledge that the primary role of health care professionals is to provide high quality patient care. However, it is also understood that the mechanics of providing health care are often very complex and involve concepts that the general public are not always familiar with. Health care professionals should always be striving to bridge the communication gap and come to a mutual understanding with patients, residents, clients and their families on the care provided. Experts in patient-centred care advise asking the patient to repeat what they understood in order to ensure communication. In many cases where patients suffer a negative outcome, the cause is outside of the health care professionals' scope of control. It is these cases that require the most empathetic and thorough explanation to patients, residents, clients or their families to ensure their understanding.

In many instances, the boards recommended in-person meetings between patients, clients, residents and/or their families, as well as health care practitioners and patient care quality officers take place to explain, in plain language, the reasons for the outcomes and care that was received. Through ongoing education and training for all staff and the awareness of empathetic communication principles, the overall patient experience will be improved.

Home and Community Care Services

The boards made a number of recommendations this year to improve the home and community care services provided across the province. In two cases, the boards made recommendations that the health authorities work with the contracted service providers to improve the services provided to home and community care clients. In another case, the boards recommended that the health authority provides the complainant with the results of a review on the process for screening home and community care clients. A recommendation was also made to the Minister of Health to review the Home Oxygen program to ensure palliative care patients were fully informed of the program and its application process.

Care Quality (Acute Care/Emergency)

Given the mandate of the boards to review complaints about care quality, it is reasonable that most complaints will fall into this category. The boards specifically made recommendations to review charting practices, mixed gender room policies, emergency department triaging practices, patient transfer or handling protocols, and staff training on topics such as: use of new equipment, procedures, patient and family communication, etc.

"Because of our autonomy and unique mandate, the Patient Care Quality Review Boards are in a powerful position to influence care quality within our health care system and our recommendations are based upon a patient's experience."

RICHARD J. SWIFT
chair, Vancouver Island Patient Care Quality Review Board

About The Patient Care Quality Review Boards

Mandate

The *Patient Care Quality Review Board Act* and External Complaint Regulation govern how the boards review complaints and what can and cannot be reviewed.

The boards may review any care quality complaint regarding services funded or provided by a health authority, either directly or through a contracted agency. The boards may also review complaints regarding services expected, but not delivered, by a health authority (e.g., a complaint regarding a cancelled surgery).

The boards may only review complaints that have first been addressed by a health authority's Patient Care Quality Office, unless otherwise directed by the minister.

If the boards receive a complaint that cannot be reviewed, the complainant is redirected to the most appropriate body for their concerns.

As a result of a review, the boards can make recommendations to a health authority or to the minister to improve the way complaints are handled, to improve the quality of patient care, or to resolve a specific care quality complaint.

Finally, the boards monitor, track, and report on care quality complaints in British Columbia.

The Review Process

Patients and their loved ones may request a review by submitting a review request form (by mail, email, online or fax) or by calling 1 866 952-2448. If the board can review the complaint, the health authority's Patient Care Quality Office will be notified and asked to provide a copy of any information relating to the complaint.

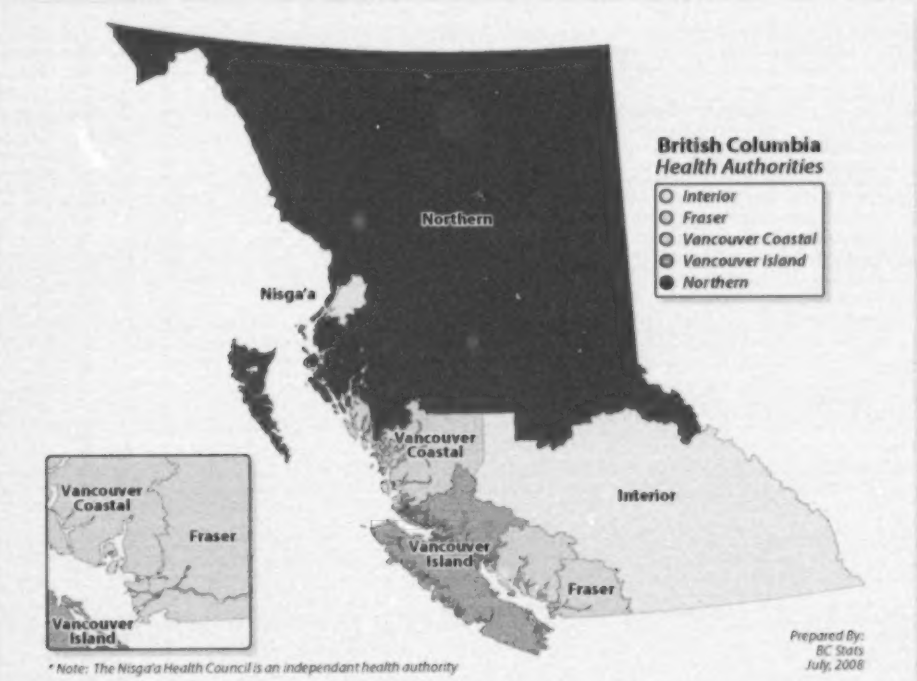
The board will review the facts and other background information, seeking expert advice and/or clarification from the health authority, the complainant, and/or other experts as required.

Once the review is complete, the board will send the complainant and the health authority a final decision letter indicating whether any recommendations have been made. The boards explain their findings and the reasoning for decisions in the letter. A copy of the letter is also sent to the Minister of Health to allow the ministry to follow up with the health authority on the implementation of recommendations.

When a board makes recommendations, the health authority will contact the complainant to discuss the outcome and any actions that may be taken to address the care quality issues highlighted by the board's review.

About the Boards | *Current Members*

Board members are appointed by the Minister of Health based on their expertise and experience. Members are eligible to serve one, two or three year terms and may be reappointed to consecutive terms at the discretion of the minister. Current health authority employees, board members, and contractors are not eligible to serve on the boards.



* Note: The Nisga'a Health Council is an independant health authority

"The Patient Care Quality Review Boards put the patient at the center of the system. Through our independent review process, every complaint has the potential to make a positive improvement to the performance quality of our B.C. system of health care."

ROGER SHARMAN
chair, Interior Patient Care Quality Review Board

Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Board

Dr. John (Jack) H. Chritchley, chair
Dr. John H. V. Gilbert, C.M.
Robert D. Holmes, Q.C.
Sandra Wilking
Dr. Naznin Virji-Babul
Janis A. Volker
R. Hoops Harrison

Interior Patient Care Quality Review Board

Roger Sharman, chair
Dr. Randall Fairey
Donna Horning
Thomas Humphries
Gloria Morgan
Dr. Robert Ross

Northern Patient Care Quality Review Board

William Norton, chair
Dr. John (Jack) H. Chritchley
Lorna Dittmar
Elizabeth MacRitchie
Allison Read

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., chair
Ann Beamish
Michael F. Patterson
Dr. Linda J.A. Thomson
G. Henry Ellis

Statistical Overview | *Patient Care Quality Offices*

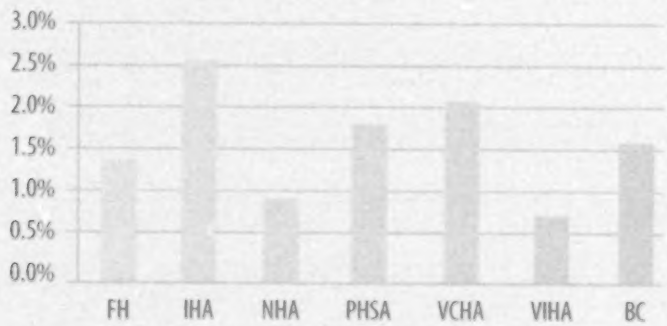
The boards collect data from the health authority Patient Care Quality Offices (PCQOs) regarding the number and type of complaints received by the PCQOs in each quarter throughout the fiscal year. In 2013/14, there were 6,473 care quality complaints (an increase of 1,915, or 42 per cent from the 4,558 complaints received in 2012/13), 169 external complaints[1] and 1,812 inquiries in British Columbia (see Appendix A for details). The boards are aware that in the last year there has been increased media promotion, enhanced patient navigation in government correspondence, improved intake categorization, and increased awareness by health professionals of the patient care quality process as a whole. All of these could be factors in the increase in care quality complaints received across the province. The table below presents the volume of care quality complaints received by each PCQO between April 1, 2013 and March 31, 2014.

TABLE 1: *Volume of Care Quality Complaints by Health Authority (including provincial totals)*

	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL 2013/14
Fraser Health	283	336	409	381	1,409
Interior Health	273	263	301	296	1,133
Island Health	362	429	419	448	1,658
Northern Health	65	80	84	81	310
Provincial Health Services Authority	129	113	132	116	490
Vancouver Coastal Health	318	356	404	395	1,473
BRITISH COLUMBIA	**1,430**	**1,577**	**1,749**	**1,717**	**6,473**

There were 6,473 care quality complaints received by PCQOs this fiscal year and 75 complaints were reviewed and completed by the boards. The boards accepted another 105 reviews this year. This suggests the vast majority of health care complaints are resolved at the health authority level. The chart below shows the percentage of care quality complaints that escalated to the boards from each PCQO over the 2013/14 period. It should be noted that this graph represents a small sample size and is subject to fluctuations year-over-year. It is not intended to be an indication of PCQO performance, but does indicate that health authorities are resolving over 98 per cent of complaints at the regional level.

Percentage of Care Quality Complaints that become PCQRB Accepted Review Requests in 2013/14



1 External complaints are defined by the ***Patient Care Quality Review Board Act*** and External Complaint Regulation, and may include complaints about services that are not funded or provided by the health authorities, or complaints that are best addressed by another entity.

Statistical Overview | *Patient Care Quality Review Boards*

In 2013/14, the boards saw a 28 per cent increase in accepted review requests – up to 105 from 82. The boards also completed 75 reviews and canceled two reviews at the request of the complainant.

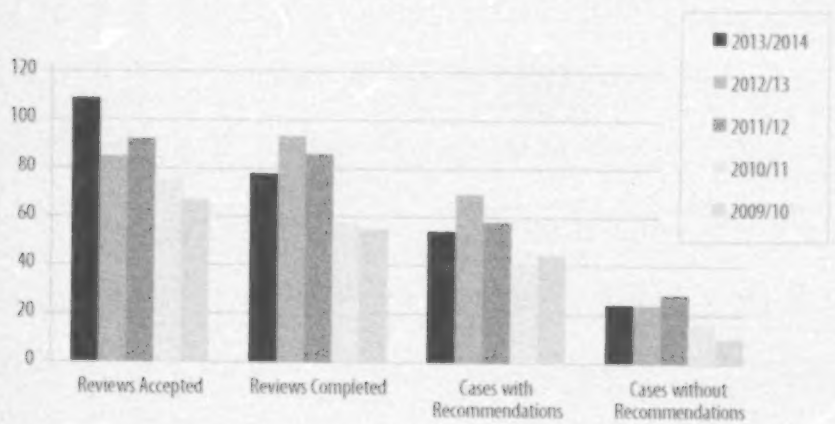
In 52 of the completed reviews (69 per cent), the boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 23 of the completed reviews (31 per cent), the boards did not make recommendations, having concluded that the quality of care provided had been appropriate or that the circumstances of the complaint did not present an opportunity for care quality improvement. The table below presents an overview of the boards' volume.

TABLE 2: *Overview of Patient Care Quality Review Board Volume*

	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	20	10	10	0
Interior Health	29	18	12	6
Island Health	13	8	6	2
Northern Health	3	2	1	1
Provincial Health Services Authority	9	10	6	4
Vancouver Coastal Health	31	27	17	10
TOTAL	**105**	**75**	**52**	**23**

The boards made a total of 84 recommendations in 2013/14 – 83 to the health authorities and one to the Minister of Health.

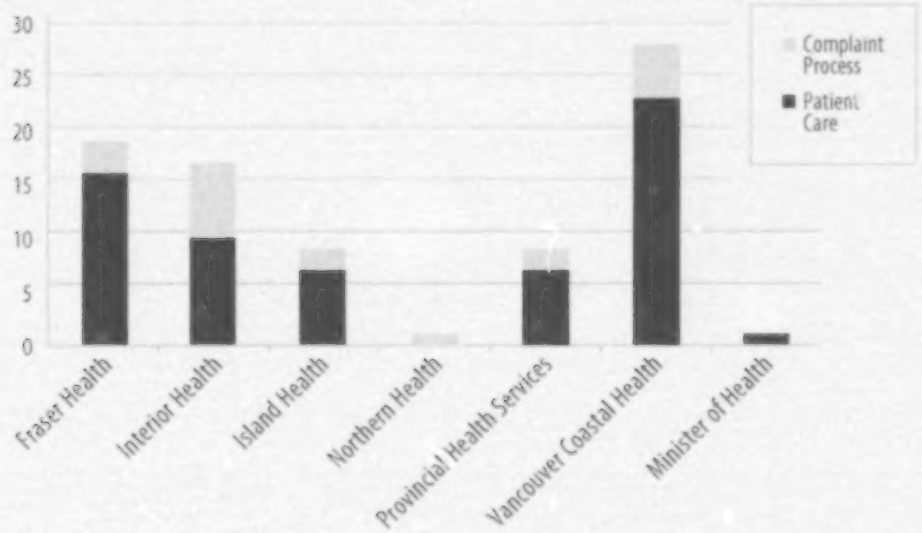
CHART 1: *Volume Comparison for Recommendations and Reviews*



Statistical Overview | *Patient Care Quality Review Boards*

Of the 83 total recommendations to health authorities, 63 were to improve the quality of patient care, and 20 were to improve the complaints process (see chart below). In 17 of the completed reviews, the boards identified opportunities for the Patient Care Quality Offices (PCQOs) to improve the quality of their investigation or response; in the remaining 58 reviews, the boards found the PCQOs had responded appropriately.

CHART 2: *Recommendations Concerning Complaints Process vs. Patient Care*



The boards also collect information regarding the timeliness of health authority responses to board recommendations. Under the *Patient Care Quality Review Board Act*, health authorities are required to respond to recommendations within 30 business days, not including statutory holidays. Health authorities achieved this timeline in 42 of the 52 reviews that resulted in recommendations.

Finally, the boards track the timeliness of our own reviews. Under the legislation, the boards are expected to complete those reviews and respond within a maximum of 130 business days. In seven cases (nine per cent) the boards exceeded this timeline. Five of those reviews were completed one day over the 130 business day deadline. The average time to complete a review and respond to the complainant was 123 business days. The median time was 127 days. On average, the boards took nine business days to provide a response following their decision. The median number of business days was ten.

Statistical Overview | *Patient Care Quality Review Boards*

The chart below represents the subjects of all the complaints reviewed by the boards in 2013/14.[1] Because the care category is quite general, and the population accessing acute care services quite large, care quality complaints are often concentrated under "Acute Care – Care." Note that one complaint may encompass more than one care issue, resulting in a higher total number of care issues versus total number of complaints reviewed.

SECTOR	SUBJECT	#
Acute Care	Care	55
	Communication	10
	Environment	7
	Attitude / Conduct	5
	Accessibility	3
	Discharge arrangements	3
	Accommodation	1
	Co-ordination	1
	Safety / Secure Setting	1
Acute Care – Cancer	Care	3
Ambulance	All Subjects	8
Ambulatory Care	Accessibility	10
	Attitude / Conduct	7
	Care	7
	Communication	2
	Financial	1
Ambulatory Care – Cardiac	Access	1
Emergency Care	Care	22
	Accessibility	5
	Attitude / Conduct	1
	Discharge arrangements	1
Home and Community Care	Accessibility	6
	Care	4
	Attitude / Conduct	1
	Administrative fairness	1
	Communication	1
	Co-ordination	1
Mental Health and Substance Use (Incl. acute)	Accessibility	5
	Care	5
	Discharge arrangements	3
	Communication	2
	Administrative fairness	1
	Financial	1
Public Health	Accessibility	1
Residential Care	Care	17
	Attitude / Conduct	3
	Communication	3
	Financial	3
	Rights to health, safety and dignity	2
	Accessibility	1
TOTAL		**215**

1 Note the Acute Care category excludes Mental Health and Addictions (MHA) because MHA is its own separate category.

Minister of Health | *Recommendations and Responses*

After completing a review, a board may make recommendations to the health authority and/or the Minister of Health to improve the quality of care and to improve the complaints process.

When making recommendations, the boards consider:

- The context of the complaint from both the health authority and the patient's perspective;
- The policies, procedures, guidelines, etc. that are applicable to the complaint;
- The evidence base for the recommendation;
- The potential impact of the recommendation; and
- The feasibility of implementing the recommendation.

The health authorities carefully consider recommendations and are required to respond, to both the board and the complainant, to indicate what action(s) will be taken to address them.

In 2013/14, the boards made one recommendation to the Minister of Health and 83 recommendations to the health authorities. The following presents each of the boards' recommendations for this reporting period, along with some highlights of actions taken in response.

Recommendations to the Minister of Health

1. The board recommended the Ministry of Health reviews the Home Oxygen program to ensure home and community care palliative patients are fully informed about subsidized home oxygen and its application process so they may apply for and receive all eligible subsidies in a timely manner.

Summary of Response:

The ministry's Home, Community and Integrated Care branch reviewed information and resource materials available for palliative home and community care clients through the ministry and HealthLink BC websites. This review determined the application process for home oxygen through the Home Oxygen program is not clear and it is also unclear home oxygen is not included in the British Columbia Palliative Care Benefits program or through home and community care.

The ministry's review supported the board's recommendation to improve information about the Home Oxygen program for palliative patients. Furthermore, it was noted that the board's recommendation was also aligned with the Provincial End-of-Life Care Action Plan for British Columbia's priority to provide individuals, caregivers and health care providers with palliative care information and resources. Therefore, the ministry implemented the recommendation to review the program and worked with regional health authorities to improve provincewide information about the Home Oxygen program and its application process for palliative clients.

Recommendations and Responses | *Fraser Health*

- Fraser Health is responsible for serving a densely populated and culturally diverse region with more than 1.6 million British Columbians.
- The board completed their review of 10 cases from Fraser Health in 2013/14, resulting in 19 recommendations from all 10 cases. Of the 19 recommendations, 16 were to improve care quality and three were to improve the complaints process.
- The board made recommendations on complaints ranging from closing the communication gap between patients and health care workers to improving home and community care services. In response to the board's recommendations, Fraser Health has reviewed its policies and health care strategies, as well as provided further information and arranged for staff education.

1. COMPLAINT REGARDING DOCTOR AND NURSING COMMUNICATION ISSUES COMPROMISING QUALITY CARE.

Recommendation:	***Response:***
i. The board recommended Fraser Health undertakes a detailed investigation, including a review of inventory and pharmacy records for the time in question; take any other steps reasonably available to clarify and confirm that the patient was not administered insulin; and provide the outcome of their review to the patient and the complainant.	***i.*** Fraser Health reported it would bring this incident to the Medicine Quality and Safety Review Committee. Additionally, Fraser Health would review the ward stock process and procedure for insulin administration with all staff and send a memo to the site regarding the expectations for all the independent double checks, steps required and the process of ensuring single patient use per ward stock vial.
ii. The board recommended Fraser Health designates an external quality care committee made up of health care professionals to conduct a thorough review of the charting of patient care at [the hospital], with a view to ensuring that it meets health authority and provincial standards; share the results of that review with all medical staff at [the hospital]; and take appropriate steps to ensure monitoring of and compliance with charting requirements	***ii.*** Fraser Health reported patient care documentation is a performance area that all health care providers are expected to be competent in. In most cases, there are regulatory/ professional and/or organizational documentation guidelines and standards. An inter-professional team will conduct a review of patient care documentation on medical units at the hospital. The team will formulate recommendations to ensure documentation guidelines and best practices are met.

2. COMPLAINT REGARDING EARLY DISCHARGE AND LACK OF COMMUNICATION ABOUT CHILDREN IN THE EMERGENCY DEPARTMENT.

Recommendation:	*Response:*
i. The board recommended [the hospital] reviews its emergency department discharge practices in relation to newborn infants brought in for care and: ***a.*** Focus upon the manner in which advice is given to parents of infants, with particular emphasis on ensuring that advice is clearly communicated and understood; ***b.*** Identify and communicate, where appropriate, what symptoms parents are to look for and when to bring the infant back in to the emergency department or to a medical clinic for further examination; ***c.*** Advise on resources and support available in the community, including available public health nursing programs; ***d.*** Follow up, where appropriate, with telephone contact with the parents or by making a referral to public health nursing services for infant care.	*i.* Fraser Health reported the following actions in response: ***a.*** The emergency department program formally presented the board's recommendations at the regional emergency department chiefs meeting and then to all emergency staff at site meetings to ensure clear communication is provided during discharge. ***b.*** The emergency department program has standardized written discharge instructions that provide advice on what to look for when children are discharged from the emergency dep rtment and when to bring the child back. These have been implemented electronically at all sites as of January 2013. ***c.*** The emergency department program will expand its patient information handouts to include information about their public health nursing program, which is available for new mothers. Contact information for Healthlink BC, which provides 24/7 telephone health advice, is already available on all discharge instructions. ***d.*** Emergency department physicians currently make followup calls to patients if deemed appropriate. Already part of physician practice.

3. COMPLAINT REGARDING COMMUNICATION AND POST-OPERATIVE DISCHARGE PLAN.

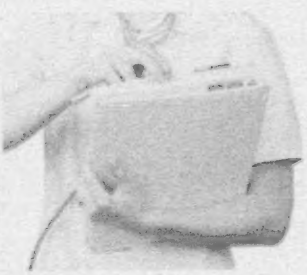
Recommendation:	*Response:*
i. The board recommended Fraser Health have its Patient Care Quality Office inform the complainant of: ***a.*** The surgeon's post-operative care responsibilities in regard to both Medical Services Plan requirements and applicable Fraser Health policies and whether they are assumed in this case; ***b.*** The identity of the most responsible physician if it was not the surgeon; and ***c.*** Whether there was a post-operative discharge care plan in place, if it was followed and, if not, why it was not followed.	*i.* Fraser Health reported the following actions in response: ***a.*** There are no particular requirements under the Medical Services Plan, but the fee code does include post-op care. There are expectations outlined in the rules and bylaws of Fraser Health indicating physicians must provide ongoing care to their patients. If unable to do so themselves, they should arrange for alternate care. ***b.*** The doctor remained the most responsible physician during the patient's first hospitalization. It is traditional practice that once a surgeon performs an operation, they remain the most responsible physician in most cases. ***c.*** The physician wrote in the discharge orders that the patient was to come to the physician`s office in one month for review. This is a traditional discharge care plan in patients who do not appear to have had any complications and do not require ongoing care with regard to dressings or drain management, etc. When the patient presented the second time with a recurrent subdural hematoma, a second physician performed the surgery and became the most responsible physician and was responsible for the patient's ongoing care. It was noted that the first physician did see the patient on three days during the second admission.

4. COMPLAINT REGARDING THE CARE PROVIDED BY HOME SUPPORT WORKERS CONTRACTED BY THE HEALTH AUTHORITY.

Recommendation:	*Response:*
i. The board recommended Fraser Health undertakes an audit of the home support services contract with [company] for this patient to ensure compliance with the provisions of that contract.	*i.* Fraser Health reported it had undertaken audits in the summer and fall of 2013 for compliance to community health worker competency completion. The second audit was to follow up on compliance to competency outcomes from the first audit. Areas of improvement were detailed, including signing off training completion and retraining and establishing a protocol for training and competency sign off. Since this audit was completed, a part time educator has been added to the staff at [company]. Fraser Health has set financial incentives to exceed pre-set targets. [Company] is currently at the base rate as it is not maintaining targets for quality performance.
ii. The board recommended Fraser Health ensures the director of home support services for Fraser Health, who is responsible for monitoring and compliance of the home support services contract with [company], is in communication with [company] when any discrepancies are noted (e.g., by patients or families).	*ii.* Fraser Health's manager/interim director of contracted services is in written contact with [company]. Currently, measureable outcomes related to service, communication and business practices are under review with a time limited expectation for compliance. Regular meetings with the [company] are conducted monthly through the Contracted Provider Quality Council, as well as separately in response to complaints. Meetings were held to request operational changes in order to address concerns from clients and families. Fraser Health has been, and will continue to follow up on all quality performance issues, with expectations of resolution within a specified period of time. Currently, Fraser Health is meeting with [company] staff every two weeks to review improvements and the sustainability of improved services.
iii. The board recommended Fraser Health evaluates the new cluster model that [company] has undertaken at [facility] to ensure that it is working effectively	*iii.* A requirement of the contract with Fraser Health is that [company] must report monthly numbers of clients receiving care in this cluster model compared to the numbers of community health workers in the team. Cluster service hours are reviewed quarterly to identify efficiencies in service delivery. All discrepancies are referred back to the agency (service provider) for correction.

5. COMPLAINT REGARDING LACK OF SERVICE FOR CHILDREN OF SCHOOL AGE WITH DIABETES.

Recommendation:	*Response:*
i. The board recommended Fraser Health requests that the Ministry of Children and Family Development clarify their nursing support services guidelines so that readers will know what to expect from that service.	*i.* In September 2013, Child Health BC released Diabetes Care in the School Setting: Evidence-Informed Key Components, Care Elements and Competencies. This report includes all aspects of diabetes care in the school setting. Delegation of care such as insulin pump management and glucagon administration is covered in this report. Nursing support services has begun educating personnel within schools to enable delegation of glucagon administration in that setting. This will be a consistent process across all health authorities and schools in British Columbia.
ii. The board recommended Fraser Health considers requesting they be represented in the Ministry of Children and Family Development Inter-Ministerial Working Group reviewing diabetes care in schools.	*ii.* Child Health BC organized a provincial working group to address the issues faced regarding diabetes care in the school setting. Representatives from all health authorities, including Fraser Health, were included in this process in addition to parents, pediatricians, diabetes educators, nursing support services co-ordinators, school administrators, and the BC Ambulance Service.



6. COMPLAINT REGARDING THE LACK OF COMMUNICATION REGARDING CARE BETWEEN CARE PROVIDERS AND COMPLAINANT.

Recommendation:	*Response:*
i. The board recommended Fraser Health conducts a review of this matter and determine what improvements can be made to ensure that elderly patients moving through multiple institutions receive appropriate care with specific focus on the following: ***a.*** Identification of who the most responsible physician is and how this is communicated to the patient and family. ***b.*** Discharge instruction communication to the patient and family. ***c.*** Communication between health providers to ensure continuity of care between facilities within the same health authority. ***d.*** Ensuring consistent social worker followup through multiple facilities. ***e.*** Providing appropriate geriatric physician consultations. ***f.*** Ensuring appropriate management and supervision of care teams includes the implementation of required policies and protocols.	***a.*** The most responsible physician is often identified on a white board in the patient's room. When patients are transferred between Fraser Health sites, a discharge summary is communicated. Fraser Health is looking at various improvement strategies on trying to assign two hospitalists to share information with each other regarding a joint patient. ***b.*** Discharge instructions are tailored to the patient's medical condition (what to expect, what to look for, when to contact a physician). A discharge is a team decision. A physician must provide the orders and may do so before all the discharge arrangements are made. Discharge is not normally a formal sit-down process with a point-by-point guideline. It is expected that patients and their family are actively involved in their health care. Patient care co-ordinators ensure discharge process is completed. This specific issue will be addressed again to ensure that every effort is made to inform families (one contact person) of transfers, as applicable. ***c.*** Sharing information with families is the role of the physician and the multi-disciplinary team who is caring for the patient. Fraser Health is working to improve resources and recognizes the importance of trying to maintain a consistent approach. ***d.*** Physicians follow the most responsible physician policy for transfer of care between facilities. It is the responsibility of the transferring physician to provide information to the receiving physician regarding the patient being transferred. *I.* ***Continuity of Care:*** Social workers should review the documentation of the previous social workers' involvement and seek clarification from previous social workers if necessary in order to follow through with supporting the development of a consistent plan of care. This was reinforced at regional social work meetings, and will be followed up by a social worker clinical practice lead at each site, as well as included in regional core education.

II. ***Social Work Assessment and Documentation:*** Fraser Health social work clinical practice leads will work with social work staff to review assessment and documentation guidelines with social workers, and to regularly review documentation to continually improve the quality of social work assessments, interventions and documentation.

III. ***Concerns Management (information for patients and families):*** A reminder will be given to social workers that if they are aware of concerns, they should inform families of the process of escalation and know about providing the Patient Care Quality Office brochure if the family appears dissatisfied with attempts to bring concerns to the team. Social workers will follow up with patients and families on relevant team decisions or recommendations related to the patient's care.

e. Fraser Health is actively recruiting new geriatricians and is looking at innovative ways to be available to general practitioners.

f. The implementation of Fraser Health program management continues to be part of a broader strategy, which aims to support the development of a more integrated health teams, including a system that is more efficient and responsive to the needs of the population.

7. COMPLAINT REGARDING INADEQUATE CARE AND POOR COMMUNICATION BY HEALTH CARE WORKERS.

Recommendation:	*Response:*
i. The board recommended Fraser Health directs [hospital] staff to review the transition between urgent care and an admitting unit to ensure consent to medical treatment is documented in accordance with the Consent for Health Care policy.	*i.* Fraser Health's emergency department managers/ directors reviewed the Consent for Health Care policy, as well as the Medical Orders for Scope of Treatment and Advance Care Planning forms with its staff at a Surrey Memorial Hospital emergency department meeting. As consent for treatment can be gained by both forms, the meeting reviewed the process to ensure that the most appropriate form is completed as an outcome to conversations with an adult capable of providing consent to health care or, if the adult is not able to provide consent, his/her substitute decision maker(s).
ii. The board recommended Fraser Health offers the complainant access to its available social work or grief counselling services. If the complainant refuses services through the health authority, the health authority should provide them with contact information for community social work, grief counselling and/or mental health services.	*ii.* Families are referred to Surrey Hospice Society for grief counselling. The Patient Care Quality Office provided contact information for the society.
iii. The board recommended Fraser Health has its Patient Care Quality Office consider, when appropriate, inviting a social worker or counsellor to family meetings to ensure family members are informed about the available bereavement services.	*iii.* Fraser Health contacted its professional practice integration partner for direction with social work involvement. The goal would be for the patient care quality officer to be able to contact the professional practice integration partner and request a social worker to be present, as applicable to the unique situation. This partnership will also allow the Patient Care Quality Office to identify families in possible need for bereavement services.

8. COMPLAINT REGARDING INADEQUATE CARE, INCLUDING MISSED APPOINTMENTS, BY HOME AND COMMUNITY CARE WORKERS.

Recommendation:	*Response:*
i. The board recommended Fraser Health intensifies its managerial efforts to monitor the delivery of services by [company].	*i.* Fraser Health reported it met with [company] representatives and has submitted its sixth formal notice of overall service quality concerns within the past year. In the letter, Fraser Health outlined continued service concerns, including complaints, responsiveness, communication and billing errors. Fraser Health outlined five specific measures to determine success for the January to March 2014 timeframe, and an additional five specific measures for continued partnership. Fraser Health followed up this letter with a meeting and outlined recommendations for improvement in the areas of intake, scheduling and new hire orientation. Ongoing communication would take place to identify concerns and work with the service provider to ensure Fraser Health clients remain safe.
ii. The board recommended Fraser Health undertakes an audit of the services provided for this client, within three months from the date of this letter, and report back to the complainant in writing.	*ii.* Fraser Health's Home Support program will conduct a comprehensive review of this client's services and will report their findings to the client directly.

9. COMPLAINT REGARDING UNEXPECTED DEATH IN AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended the Patient Care Quality Office (PCQO) arranges a family conference with the family, a social worker, and the physicians involved in the patient's care to: ***a.*** Provide information on the patient's health status before and after the two heart surgeries, what the prognosis was for recovery and what [the complainant's] health status was at the time of the transfer to [unit] and the reason for transfer. ***b.*** Explain what happened to the patient on [unit] between 16:30hrs and 20:30hrs and what the cause of death was. ***c.*** Provide confirmation to the complainant that [the complainant's] presence at the patient's bedside would not have made a difference in the outcome. ***d.*** Explain what the purpose of a Code Blue is and why it was called in this case. ***e.*** Provide an explanation for why the PCQO response was six months late.	*i.* Fraser Health's Patient Care Quality Office committed to arrange to have a family meeting to discuss any outstanding concerns within three months or sooner, based on family and physician availability. ***a.*** The care team had decided the patient could be moved to a step-down unit. The complainant believed this decision was premature. However, based on the information in the medical record it would appear that although the patient was still very sick and in need of medical care, [patient was no longer benefiting from, or in need of, the level of critical care nursing provided in the unit. ***b.*** On review of the entire medical chart, the patient was visited on as many as nine occasions from 1245hrs to 1930hrs when [patient] was found to be in distress. There were 24 separate notations made in the charts during the six hours and 45 minutes the patient was in the unit. This indicates a high level of observation by the staff and indicates staff was attentive and addressing [the patient's] needs. ***c.*** It appears that this patient had multi-system failure as a result of prolonged complex illness. Unfortunately, having the complainant at the bedside would have not made a difference to the outcome. ***d.*** An advanced care directive was not present in the medical records. Therefore, the decision to call a Code Blue was the appropriate course of action given the patient's presentation at the time. A Code Blue is called when a patient goes into cardiac or respiratory arrest. Once the code has been called, a resuscitation team responds to the unit to ensure the immediate provision of basic life support and advanced cardiac life support. ***e.*** The Patient Care Quality Office worked with designated leads and explained it was a time of transition for some of the managers. The office apologized for the delay.
ii. Ensure all pertinent staff is trained on the use of all new equipment and that training take place prior to the equipment being placed/used on the floor/ward.	
iii. The board recommended the chief of staff reviews the discharge summary to ensure that a cause of death is identified.	

	ii. In-service training is given by the company and/or clinical nurse educator whenever a new procedure or new product is introduced. Currently, there is no way to track if staff attended the in-services on feeding tubes. Feeding tube insertion is a basic nursing skill. What is different here is the type of tube and whether there was a manufacturing issue. Cardiac services staff training is being tracked and documented, with expectations that all staff will be trained before using new equipment. *iii.* The head of cardiac services reviewed the chart. The cause of death was multi-organ failure and it was determined all appropriate protocols and pathways were followed. This was a very high-risk case.

10. COMPLAINT REGARDING RESIDENTIAL CARE RATE REDUCTION.

Recommendation:	***Response:***
i. The board recommended Fraser Health amends the Physician's Medical Certification of Death to recognize that the patient was a non-smoker.	*i.* In discussions with the Information Privacy Office and Vital Statistics, the only course of action was to discuss the Medical Certificate of Death (MCD) with the attending physician. The physician, upon reviewing the documentation in the chart and in consultation with the College of Physicians and Surgeons, decided the only amendment they would make, based on documentation in the chart, was to change the MCD from "smoker" to "ex-smoker." An update was sent to Vital Statistics.

Recommendations and Responses | *Interior Health*

Interior Health is responsible for a broad geographic area of over 216,000 square kilometres, including both larger cities and rural communities, with a population of more than 742,000 people.

The board reviewed 18 cases from Interior Health in 2013/14, resulting in 17 recommendations in 12 of those cases - 10 for care quality improvement and seven for improving the complaints process. There were no recommendations in six of the cases.

Many of the board's recommendations to Interior Health focused on improving communication with patients, residents, clients and/or their families. For example, recommending in specific cases that the health authority meet or correspond with patients, clients, residents or their families to further explain the care provided. In two cases, the board made recommendations where it observed the Patient Care Quality Office had difficulty obtaining information from program areas to inform its investigation.

In response to the recommendations, Interior Health will provide training to staff on facility policies, with particular attention to falls management. Furthermore, numerous complaints were followed up by the health authority as the board recommended improved and/or additional communication with complainants to ensure their concerns were addressed.

1. COMPLAINT REGARDING LACK OF CONSENT FOR AMPUTATIONS.

Recommendation:	*Response:*
i. The board recommended Interior Health develops a protocol that will provide for the recording of a patient's understanding of a procedure, his/her consent to it and, where possible, the attending physician obtains the patient's written consent to the procedure.	*i.* Interior Health reported that policy AL01000 Consent — Adults already encompasses the elements as described in the recommendation. 3.12 Documentation of Consent — the health care provider must document the consent process on the adult's health record.

2. COMPLAINT REGARDING COMMUNICATION, FAMILY INCLUSION ON CARE PLANNING AND PALLIATIVE CARE PRACTICES.

Recommendation:	*Response:*
i. The board recommended Interior Health follows up with the complainant with an update on changes developed out of the feedback and recommendations provided from the family, as well as from the reviews conducted by the Medical Quality Advisory Committee and the Palliative Care Committee.	*i.* Interior Health reported it will provide a follow-up letter to the complainant and copy the board on the response.

3. COMPLAINT REGARDING WAIT TIME IN THE EMERGENCY DEPARTMENT.

Recommendation:	*Response:*
i. The board recommended the Interior Health Patient Care Quality Office provides the complainant with an additional response including an explanation of: *a.* Canadian Triage and Acuity Scale guidelines. *b.* The Patient Care Inquiry (PCI) system and how it is used. *c.* Who is responsible for entering information into the PCI system and when it must be entered? *d.* Why there is a discrepancy in timeline in the response letter to the complainant (i.e., 0300 hrs versus 0520 hrs on the patient chart)? *ii.* The board recommended the triaging procedure be reviewed by a senior ophthalmologist at [hospital] emergency department for both the timeliness for the patient being seen and whether adequate assessment of threat to vision was practiced.	*i.* Interior Health reported it will provide a follow-up letter to the complainant and copy the board on the response. *ii.* Interior Health reported it will request that the department head for the emergency department at [hospital] review the circumstances of this case. The standard of care that would be required would be that of a qualified emergency department physician as there would never be an ophthalmologist attending in the emergency department.

4. COMPLAINT ABOUT ALLEGED INAPPROPRIATE STAFF ACCESS TO INDIVIDUAL'S MEDICAL RECORDS.

Recommendation:	*Response:*
i. The board recommended that in the future, if the Patient Care Quality Office (PCQO) is not satisfied with the information obtained from the program area during an investigation, they request further follow up until they have the information needed to provide a comprehensive response to the complaint. *ii.* The board recommended the Interior Health PCQO reopen the complaint, ensure a thorough investigation is conducted, and provide a response to the complainant.	*i.* The director of risk management at the Interior Health PCQO committed to reviewing this case at an upcoming team meeting with all the PCQO members to ensure all members understand their responsibility to facilitate a thorough investigation and provide a detailed response to complainants. *ii.* The health services director and human resources business partner at the facility had already initiated a human resource-led investigation into the events described by the complainant. This was prompted by the request for review to the review board and subsequent conversations with the review board officer assigned to the file. A thorough investigation has been conducted and a response provided to the complainant.

5. COMPLAINT ABOUT FAILURE TO PROVIDE PROPER HOME AND COMMUNITY CARE SERVICES.

Recommendation:	*Response:*
i. The board recommended Interior Health have its Patient Care Quality Office (PCQO) provide the complainant with the results of the team leader's review of how to improve the screening of potential home and community care patients to determine whether they meet its program criteria. *ii.* The board recommended Interior Health ensures its program areas provide the PCQO with the information necessary to respond to patient concerns in a timely manner	*i.* A working committee has been critically reviewing all services provided by the community clinics and is recommending appropriate expansion or deletion of services. There is a guiding principle for the new clinic model: all clients will be seen in the clinic unless they have an exceptional need that requires them to be seen in the home. This will shift services away from the home setting in a significant way, allowing increased capacity, consistency and efficiency. The committee has been tasked to have recommendations to the Community Integrated Leadership Team by mid-October. *ii.* The director of risk management at the Interior Health PCQO will take this recommendation to the senior executive team for discussion and response.

6. COMPLAINT REGARDING AN IMPROPER TRANSFER IN HOSPITAL BED LEADING TO FURTHER INJURY.

Recommendation:	*Response:*
i. The board recommended Interior Health directs the medical chief of the rehabilitation unit at [acute care facility] to undertake a quality improvement review of this incident to ascertain whether improvements can be made in regards to interdisciplinary documentation, medical charting, patient transfer and handling protocols.	*i.* Interior Health staff believe that with the implementation of 48/6 at [acute care facility], perhaps a similar circumstance would be avoided. 48/6 is designed to enable inter-professional information sharing, with a consistent approach to care. Interior Health is introducing 48/6 — a model of care that focuses on six basic functional care areas known to be barriers to discharge, regardless of primary diagnosis. The 48/6 care delivery model will apply to all admitted inpatients (except obstetrics and newborns). Using a phased approach, 48/6 will be implemented at all 22 Interior Health acute sites by March 31, 2014.

7. COMPLAINT REGARDING POOR CARE IN AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Interior Health have its Patient Care Quality Office provide the complainant with the results of the unit manager's review of how to improve infection control measures so that immune compromised patients receive appropriate care.	*i.* Interior Health accepted the board`s recommendation and will also provide feedback on other actions at [hospital] that are relevant to this case.

8. COMPLAINT REGARDING INJURY SUSTAINED IN FALL WHILE IN RESIDENTIAL CARE.

Recommendation:	*Response:*
i. The board recommended Interior Health directs [company] to provide education to staff on [facility] policies, with particular attention to the procedures contained in the *Clinical Manual on Falls or Injury: Management of Residents at High Risk.* *ii.* The board recommended Interior Health directs [company] to review its own policy regarding fall management and ensure the policy aligns with the availability of professional staff to complete the assessment of the resident who has fallen.	*i.* Interior Health accepted the recommendation as it was written. *ii.* Interior Health's residential services leadership will continue to work with the management of [company], [residential care facility], in the context of the existing quality improvement plan and ensure that the above recommendations are included in that plan.

9. COMPLAINTS REGARDING THE PAIN MANAGEMENT AND WOUND CARE RECEIVED AT RESIDENTIAL CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Interior Health reviews its wound care policies regarding the prevention and management of pressure sores for those patients assessed as a high-risk on the Braden Scale to ensure adequate provisions are in place for the management of the care of those patients (such as through the Pixalere System) by all medical health care providers.	*i.* Interior Health has recently seconded an individual into the Professional Practice Office as project leader. Their role is to create decision support tools to support staff practice in the management of wound care. Pressure ulcer prevention and treatment will be key decision support tools.

10. COMPLAINT REGARDING MIXED GENDER ROOMS AND HOSPITAL CLEANLINESS.

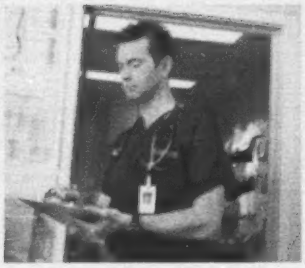
Recommendation:	*Response:*
i. The board recommended Interior Health ensures all applicable health care facilities are complying with the Ministry of Health policy Assignment of Hospital Rooms to Support Patient Privacy, Dignity and Safety, and each facility has a protocol consistent with this policy for assigning patients to hospital rooms. *ii.* The board recommended mechanisms put in place to ensure the facilities can meet their requirements under the protocols.	*i & ii.* A review of all facility protocols will be undertaken to ensure compliance with Interior Health Policy AH3000: Assignment of Hospital Rooms to Support Patient Privacy, Dignity and Safety. Facility protocols will be standardized. Once this process is completed, the new standardized protocols and expectations to ensure compliance will be communicated to all those in leadership positions at facilities that are responsible for compliance with the AH3000 policy.

11. COMPLAINT REGARDING PSYCHIATRIC CARE AND DISCHARGE PLANNING FROM AN ACUTE CARE FACILITY.

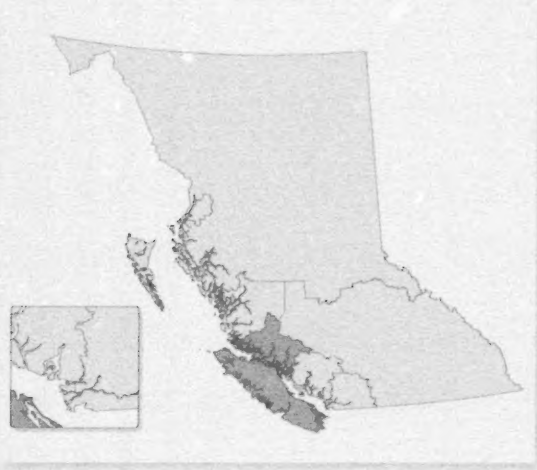
Recommendation:	*Response:*
i. The board recommended Interior Health conducts a review of this case, with specific focus on: *a.* Why there was no follow up by the emergency room psychiatric assessment service nurse as per the physician's order. *b.* Why the patient's severe anxiety rating wasn't followed up prior to being discharged. *c.* Upon completion of the review, the Patient Care Quality Office meets with the complainant to discuss the findings and outcomes of the review.	*i.* Interior Health reported it has previously reviewed and interviewed staff involved in this case. It had not investigated why there was no follow up by the emergency room psychiatric assessment services as this was never identified as an issue. The urgent response psychiatric assessment service at [facility] is available in the emergency department. Once the patient is transferred to the ward, the patient is seen by a social worker. Staff discussed the timing of the assessment with the social worker involved and determined the order was written on [date], two days after [patient] was admitted to the ward. Due to illness, the ward social worker completed the assessment three days later. At the time, both clinicians involved felt the discharge plan and follow-up arrangements were appropriate and that there was no need for further hospitalization. These were judgments made with the information available at the time.

12. COMPLAINT REGARDING A MEDICATION ADMINISTRATION ERROR.

Recommendation:	*Response:*
i. The board recommended Interior Health conducts a formal quality assurance review of the event, with a focus on improving procedures and the prevention of future occurrences, including statements from all relevant parties (e.g., registered nurse, emergency department manager, hospitalist), the consideration of any previously proposed improvements, and that the findings and any recommendations be shared with the complainant.	*i.* Interior Health followed the process laid out in Interior Health policy AK0400 Incident Management and reviewing this medication event. The policy indicated that for events that result in moderate harm to a patient, the manager will: ▸ Review the incident report for completeness; ▸ Review and co-ordinate with QIPS/RM staff, investigation of incident and any plans for incident debriefing; ▸ Review documentation on health record; ▸ Complete investigation and follow-up report; and ▸ Track any recommendations for quality improvement. A Patient Safety Learning System (PSLS) event was entered within 45 minutes of the event occurring, which is considered a reasonable time frame given the responsibilities and tasks of a nurse during a shift. A review occurred and was documented in PSLS. Significant vacancies have been filled in the time the review was ongoing. The majority of emergency department staff (approx. 95 per cent) has completed an Interior Health I-Learn Safe Medication Management Practices online module. The manager will ensure the remaining staff members will complete the training.



Recommendations and Responses | *Island Health*



Island Health (formerly Vancouver Island Health Authority) is responsible for more than 765,000 people spread over the Islands and the Mainland.

The board reviewed eight cases from Island Health in 2013/14, resulting in nine recommendations in six of those cases - seven recommendations were for care quality improvement, while two were to improve the complaints process. The board made no recommendations in three cases.

The board made multiple recommendations on the themes of discharge arrangements, communication and staff training. Recommendations included improving communication with families and patients and to provide patients admitted under the *Mental Health Act* with information about their admission as soon as possible.

Island Health took action by developing a series of training sessions for staff, as well as ensuring patient communication would occur in a timely and effective manner and that a delirium management care and charting protocol would be completed and fully implemented.

1. COMPLAINT THAT SEPSIS PROTOCOL WAS NOT FOLLOWED, LEADING TO BLOOD INFECTION.

Recommendation:	***Response:***
i. The board recommended the hospital uses this case as a learning opportunity for both emergency department staff and family practitioners across the health authority to remind them that, even when clinical standards and protocols appear to be met, the patient's condition can change suddenly and there is a need to be vigilant when treating patients with staph infections.	***i.*** Island Health reviewed this case with the staff and physicians who provided care to the patient during the patient's two visits to the emergency department. As of 2013, the emergency department has begun posting departmental sepsis data for emergency staff to educate and raise awareness.

2. COMPLAINT REGARDING THE LACK OF A CT SCAN AND IMPROPER CARE.

Recommendation:	*Response:*
i. The board recommended Island Health ensures when the Patient Care Quality Office is setting up a care conference for the patient and/or their family, prior to the meeting date, relevant and helpful information is communicated to the patient and/or family, including: a list of meeting attendees, their role in the meeting, and the option to have an advocate, friend or family member attend with them.	*i.* The recommendation was reviewed by the Patient Care Quality Office team leader with staff at a team meeting to ensure that it is now standard practice.

3. COMPLAINT ABOUT POST-OPERATIVE NURSING CARE AND LACK OF COMMUNICATION LEADING TO DEATH.

Recommendation:	*Response:*
i. The board recommended all [facility] staff be reminded of the importance of listening to family members with regard to changes in a patient's behaviour or symptoms as they know the patient's personality better than staff and often spend more time at their bedside.	*i.* Upon followup with the secretariat, the scope of this recommendation has been modified to ensure followup specifically with the nursing staff. Island Health reported that the unit manager would provide a reminder to staff through an information sharing session at a staff meeting by Oct. 31, 2013.
ii. The board recommended the clinical nurse educator reminds staff that all concerns voiced by family or friends regarding a patient be recorded on the chart in the progress notes.	*ii.* Island Health`s clinical nurse educator has provided information sessions to the staff and will provide a reminder in the unit binder for orientation by Oct. 31, 2013.
iii. The board recommended the hospital conducts a comprehensive review of its policies and procedures directing the monitoring and supervision of its medical health care providers.	*iii.* Island Health indicated that a review of all policies related to monitoring performance of health care providers will be completed by Oct. 15, 2013.
iv. The board recommended Island Health ensures [hospital] staff are educated about the role of the Patient Care Quality Office and of their responsibility for referring care quality complaints to it.	*iv.* Island Health reported that an in-service was provided by the Patient Care Quality Office team leader to [hospital] staff on April 24, 2013.

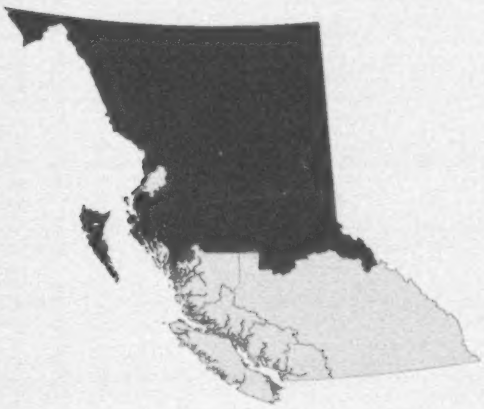
4. COMPLAINT REGARDING INVOLUNTARY ADMISSION UNDER THE *Mental Health Act*.

Recommendation:	*Response:*
i. The board recommended Island Health ensures involuntary patients are provided a Form 13 as soon as possible after admission, or that an explanation is documented within the patient's medical record if the provision of this information is delayed.	*i.* Island Health reported all relevant mental health and substance use program co-managers will be instructed to remind their clinical teams to provide Form 13 to involuntary patients as soon as possible after admission and to document within the patient's medical record if the provision of this information is delayed. This will be completed and fully implemented by Jan. 22, 2014.

5. COMPLAINT ABOUT PREMATURE PALLIATIVE CARE DIAGNOSIS AND POOR CARE AND COMMUNICATION.

Recommendation:	*Response:*
i. The board recommended the chief of staff for [hospital] ensures physicians and nurses provide and document delirium and dementia assessments and care, in accordance with Island Health's Interprofessional Practice & Clinical Standard Guideline for Delirium Watch in Adult Acute Care.	*i.* Island Health reported the Interprofessional Practice and Clinical Standard guideline 12.2.22G, dated December 2007, titled "Delirium Watch in Adult Acute Care" would be reviewed by the chief of staff, the seniors nurse and a geriatrician (to be identified from [hospital]) to develop an education and implementation plan. A delirium management care and charting protocol will be completed, fully implemented and shared with all [hospital] medical staff by Sept. 1, 2014.
ii. The board recommended the chief of staff for [hospital] ensures discharge summaries are completed in a timely manner.	*ii.* Island Health reported the chief of staff would inform all [hospital] medical staff of the vital need for timely discharge summary dictations. This will be done by e-mail, memo, posting in doctors' lounge and repeated reinforcement at monthly medical staff meetings. The expected discharge dictation should occur within 30 days of discharge. The chief of staff will monitor compliance. This action will be completed and fully implemented by April 30, 2014.

Recommendations and Responses | *Northern Health*

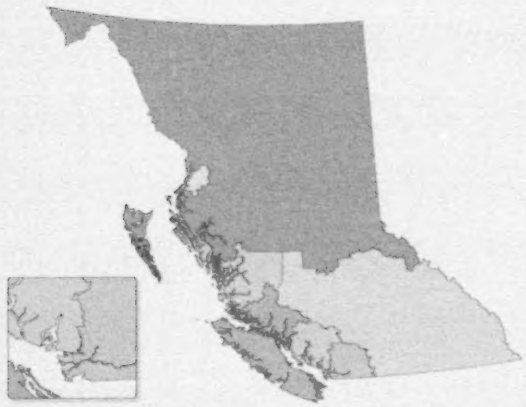


Northern Health is responsible for serving over two-thirds of B.C.'s landscape, with about 300,000 people spread over a broad geographical area.

The board reviewed two cases from Northern Health in 2013/14, resulting in one recommendation for improving the complaints process. There were no recommendations in the other case.

1. COMPLAINT REGARDING DISCREPANCY BETWEEN PATHOLOGY REPORTS AND INCOMPLETE PATIENT CARE QUALITY OFFICE RESPONSE.

Recommendation	*Response*
i. The board recommended Northern Health have its Patient Care Quality Office investigate and respond to the complainant's specific concerns, including: ***a.*** What caused the delay in completing the diagnostic report for the bilateral mammogram? ***b.*** How did the floater of gastric antral mucosa appear in the biopsy sample? ***c.*** Did these incidents adversely affect [the patient's] care?	*i.* Northern Health provided a letter to the complainant to further explain the specifics of the care provided.



Instead of a geographic region, the Provincial Health Services Authority (PHSA) is responsible for specific provincial agencies and services. There are numerous agencies and programs, which fall under the purview of the PHSA. These include: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Mental Health and Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC, BC Ambulance Service, BC Autism Assessment Network, Health Shared Services BC, PHSA Aboriginal Health program, Provincial Blood Co-ordinating Office, Provincial Infection Control Network of BC, Provincial Surgical Services program, Provincial Emergency Services project, trauma, specialized diagnostics, specialized cancer surgery and telehealth.

The board reviewed ten cases from PHSA this period, resulting in nine recommendations in six of those cases — seven for care quality improvement and two for improving the complaints process. There were no recommendations in four of the cases.

Because of PHSA's specific population, the board received fewer review requests from those patients, clients and residents whom accessed these provincial services. The board made recommendations relating to improving staff training and ensuring high quality patient care by paramedic staff.

1. COMPLAINT REGARDING PRESUMED DIAGNOSIS AND PRESENTATION OF MEDICAL ISSUE BY BC AMBULANCE SERVICE ATTENDANTS.

Recommendation:	***Response:***
i. The board recommended the BC Ambulance Service manager responsible for training uses this matter as a case study for future learning and identify training opportunities that pertain to transporting patients suffering from low blood pressure out of narrow or confined spaces.	*i.* BC Emergency Health Services is continuously improving the content and delivery of clinical education to their paramedic professionals. BC Ambulance Service has a committee, which sets educational priorities that will receive the recommendation for formal consideration and inclusion in relevant curricula. The clinical leaders who participated in the review of this care quality complaint file have also received the recommendation and will determine the best way to weave this case into future discussions and informal learning opportunities to better serve patients.

2. COMPLAINT REGARDING THE CARE PROVIDED BY BC AMBULANCE SERVICE ATTENDANTS.

Recommendation:	*Response:*
i. The board recommended the Provincial Health Services Authority conducts a review, as suggested by BC Ambulance Services Rural Operations – Patient Care Quality Review Final Report, to engage an interdisciplinary stakeholder group to review the management of the client as a high resource client with complex issues and needs.	*i.* BC Emergency Health Services (BCEHS) reported it will further review the complaint's unique care requirements, ensuring a continued multidisciplinary approach that includes the regional/local area medical director in a care planning process. BCEHS has previously engaged in a similar process when the need for a multidisciplinary care plan was identified.
ii. The board recommended the Provincial Health Services Authority considers implementing a process where all high-resource cases are reviewed, with relevant external partners, to develop a collective care plan to help manage the unique needs of these clients.	*ii.* Prior to the case in question, BCEHS had already identified an opportunity to reduce numbers of calls by high volume users through appropriate referrals and a case management structure. A preliminary proposal for a pilot project has been presented to operational management. Next steps include the development of a business case that supports quality improvement.

3. COMPLAINT REGARDING THE CARE PROVIDED BY BC AMBULANCE SERVICE ATTENDANTS.

Recommendation:	*Response:*
i. The board recommended BC Ambulance Service follows the Abuse of Patients Investigation procedure, conduct a complete investigation into the complainant's allegations by obtaining and taking into account: ▸ statements from all witnesses; ▸ any police report available; ▸ if necessary, obtaining permission from the complainant to obtain relevant medical records pertinent to the complaint; ▸ any further information that the complainant may provide, including any new information not addressed in the complaint; and ▸ thereafter providing to the complainant a full response to their complaint, including the results and conclusions of the investigation and an explanation of any steps being taken as a result.	*i.* The referenced Allegations of Abuse of Patients policy was created in 1996 and has never been updated. The policy has subsequently been removed (along with several others) from the BC Ambulance Service policy intranet site pending further review. The Provincial Health Services Authority will take steps to determine if there are any further witnesses or any new information available. The complainant will be provided with the results of the updated review and any actions taken.

4. COMPLAINT REGARDING THE LACK OF URGENCY BY BC AMBULANCE SERVICE ATTENDANTS CONTRIBUTING TO PATIENT'S DEATH.

Recommendation:	*Response:*
i. The board recommended BC Ambulance Service (BCAS) conducts a quality assurance review of this case, including: complete hospital charts, information from medical professionals, and interviews with the paramedics and the complainant. The complainant should then be provided with a full explanation of what happened, what decisions were made, why they were made, a clear explanation of why the patient was not ready when the critical care transport arrived, and what treatment was received until [the patient] was transported.	*i.* BC Emergency Health Services (BCEHS) confirmed a formal quality assurance review will be undertaken at the request of the BCEHS Provincial Quality Council. Given that the identified concerns extend to care provided prior to the arrival of the BC Ambulance Service critical care team at Chilliwack General Hospital, both Fraser Health and Vancouver Coastal Health have been invited to participate in a joint review process under the recently amended quality review provisions of section 51 of the *Evidence Act*. The Provincial Health Services Authority committed to do everything possible to provide the complainant with the results of the review in order to address the concerns.
ii. The board recommended BCAS reviews their complaint investigation process to identify and make improvements to the process so that their responses provide meaningful answers to the complaints brought forward and consider all of the relevant evidence.	*ii.* The Provincial Health Services Authority has clearly established expectations regarding quality reviews and BCEHS is expected to meet these standards by providing a first response that effectively addresses the concerns raised by a complainant.

5. COMPLAINT REGARDING THE ARRIVAL TIME OF ADVANCED CARE PARAMEDICS.

Recommendation:

i. The board recommended the health authority provides a detailed explanation to the complainant regarding BC Ambulance Service (BCAS) coverage in Surrey and its adequacy including:

- *a.* Station and ambulance coverage in Surrey compared to Vancouver and the ratio of ambulance allocations by population;
- *b.* What the average response time is in Vancouver and a comparison to Surrey;
- *c.* What has been done since September 2011 to improve BCAS coverage and response times in Surrey and what other improvements are planned to be implemented?

ii. The board recommended the health authority completes the clinical review of this matter as was indicated in the review completed by BCAS.

Response:

i. Information regarding the ratio of ambulance allocations by population is not available at this time. Call volume is generally considered to be a key driver of resource allocation and has been referenced instead.

- *a.* Within Surrey, there are currently eight 24 hour ambulances, seven peak time ambulances, and two transfer ambulances. There are three ambulance stations in Surrey and one on the border between Surrey and North Delta.
- *b.* At the moment, there is no published response time standard for BC Ambulance Service (BCAS) as BC Emergency Health Services works to revise its suite of key performance indicators. Historical measures for response time have been based on the percentage of responses to the highest acuity based on call-taking assessment using Medical Priority Dispatch System protocol in less than nine minutes in urban areas.

  What is the average response time for an ambulance in Surrey? Is the targeted response time being met? If not, what is being done to address this?

  Response time is tracked based on the metric explained above. From January 2011 to March 2014, BCAS met this timeline roughly 40 per cent of the time.

  In response to the Surrey situation specifically, additional advanced care paramedic resources have been moved into the area and staggered start times have been implemented in an effort to provide more resources during peak times.

  These targeted strategies have allowed BCAS to respond to an increased call volume of 13.5 per cent in the Surrey area in the past two years, while moving the response time target slightly in the positive.
- *c.* The Medical Priority Dispatch System (MPDS) protocol is designed to generate an acuity level based on 9-1-1 caller information that then drives resource allocation. The highest standards for MPDS protocol adherence are 90 – 95 per cent of all audited calls in six areas. BCAS scores for October, November and December 2013 were 96.27 per cent, 95.8 per cent and 95 per cent respectively.

	October, November and December 2013 were 96.27 per cent, 95.8 per cent and 95 per cent respectively. The BCAS Resource Allocation Plan has been reviewed and revised. The review analyzed clinical and operational data from over 630,000 calls and nearly 900 patient conditions to validate the clinical appropriateness of assigned resources. Further information on the resource allocation plan can be found at: *www.bcas.ca/wp-content/uploads/2013/12/RAP-Review-Summary-Report-2013.pdf* *ii.* BC Emergency Health Services completed the clinical review as indicated regarding [patient's] care and provided the following feedback: Based on a review of the defibrillator data, which detects a number of parameters related to CPR performance, the director was satisfied the CPR provided by the fire fighters and the paramedics was of high quality and was appropriate to give the patient the highest possible chance of survival. BC Ambulance Service is very focused on the quality of CPR and on optimal out of hospital care in order to give patients the best possible chance of survival.

6. COMPLAINT REGARDING CARE AND CONDUCT OF BC AMBULANCE SERVICE PARAMEDICS.

Recommendation	***Response:***
i. The board recommended the Provincial Health Services Authority Board reviews the following: *a.* The lack of charting and comprehensive assessment referred to in the advanced care paramedic quality improvement co-ordinator's report; and *b.* Whether the allegations of discriminatory treatment were received by the paramedics at the time of care, and if so, whether due consideration was given by the BC Ambulance Service (BCAS) with regard to the BCAS Code of Ethics.	*i.* Assessment and documentation practices have been reviewed with the involved paramedics as part of an education-based discussion. All BCAS paramedics will receive detailed additional training regarding documentation practices and requirements as part of the planned implementation of an electronic Patient Care Record system, anticipated in the fall of 2014. *ii.* There was no information to suggest the paramedics received any indication of allegations of discriminatory treatment during the short duration of their interaction with the patient and family.

Vancouver Coastal Health is responsible for serving two densely populated regions, with more than one million people.

The board reviewed 27 cases from Vancouver Coastal Health in 2013/14, resulting in 28 recommendations in 17 of those cases — 23 were for care quality improvement, while five were to improve the complaints process. The board made no recommendations in ten cases.

The recommendations to Vancouver Coastal Health covered a broad range of issues, with communication being a major theme with regard to: discharge planning, respectful communication, and other issues. In response, Vancouver Coastal Health has had various relevant staff members meet with patients and their families, and has reviewed and improved numerous policies and procedures.

1. COMPLAINT REGARDING APPOINTMENT BOOKING AND TIMES FOR SPECIALIST APPOINTMENTS.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health ensures the Pulmonary Hypertension Clinic at Vancouver General Hospital involve the patient and [the patient's] family in respectful discussions regarding the possibility of transferring care closer to home in the future.	*i.* Vancouver Coastal Health allowed the patient some time to discuss their needs with [the patient's] physician. Vancouver Coastal Health remained willing to support their plans to the best of their operational ability and the team is now in contact with the patient to explore alternatives. The clinic has also accepted the suggestion of having Travel Assistance Program (TAP) forms at hand at the clinic in the event the patients and their referring physicians have not otherwise made TAP arrangements.

2. COMPLAINT ALLEGING A PREMATURE DISCHARGE FROM AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reviews discharge planning in this case, with a view to improve the planning process for high risk patients, emphasis on communication with patients and their family, and identifying and ensuring the availability of necessary home and community supports.	*i.* The emergency team had reviewed the circumstances of this case as part of the initial review, and has once again reflected on the importance of ensuring that patients and family members who indicate their understanding and acceptance of the discharge plan do, in fact, understand. As with the Home is Best program in place across inpatient settings, the emergency team strives to effectively communicate with colleague services (in this case, Spine) to ensure that evolving plans are clearly communicated within and among services, with the patient and family, and that any changes in plans are well communicated and safety implications confirmed.

3. COMPLAINT ALLEGING AN INADEQUATE CARE PLAN FOR A MENTAL HEALTH RESIDENT.

Recommendation:	*Response:*
i. The board recommended the patient's care plan be reviewed in accordance with Sections 1 and 3 of the Residents' Bill of Rights, with active participation and input by the patient and members of both [facility] staff and the Richmond Mental Health team, and that a current copy of the revised care plan be kept readily available for all parties.	*i.* The client's care plan is being recorded and reviewed in accordance with the Residents' Bill of Rights using the Wellness Plan, which records the client's perspective and the staff's perspective on goals and actions. This plan is available to all authorized parties.

4. COMPLAINT ALLEGING A MISREAD OBSTETRIC ULTRASOUND BY AN UNQUALIFIED RADIOLOGIST.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health provides the complainant with the full hospital records, including any images pertaining to her obstetrical ultrasound in January 2009.	*i.* The patient's full medical record and plates of images captured from the obstetrical ultrasound study have been provided to the patient.
ii. The board recommended Vancouver Coastal Health directs the Patient Care Quality Office to review their intake procedures to ensure that matters affecting the quality of care of patients, expressed by patients and families, should be treated as complaints and not as requests for information, as per the *Patient Care Quality Review Board Act.*	*ii.* The Patient Care Quality Office has taken the opportunity to review its intake procedures and the correct categorization of contacts with patients and others, and to reinforce the awareness with other programs and services that may be contacted by patients of the importance of engaging the Patient Care Quality Office in the management of concerns, consistent with the *Patient Care Quality Review Board Act.*

5. COMPLAINT REGARDING POOR CARE AND AN INSUFFICIENTLY INDIVIDUALIZED CARE PLAN.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reviews the capacity of the CareCast pharmacy information system to identify that lactulose is contraindicated in persons with lactose intolerance.	*i.* Vancouver Coastal Health is in the process of updating their clinical information systems to a more modern system, which will feature many new safety features, including clinical decision support as suggested.
ii. The board recommended Vancouver Coastal Health reviews the effectiveness of the current system in place to communicate patient allergy and sensitivities to the physicians, pharmacy and nurses caring for the patient.	*ii.* The clinical leaders involved in this case confirm that there are systems in place, but they were not effective in this case, most notably due to the lapse in knowledge of the impact of lactulose and lactose intolerance. This gap has been remediated in the clinical guidance tools for staff.
iii. The board recommended Vancouver Coastal Health reviews the Allergy / Intolerance Status form in order to provide more clarity with regards to the patient's allergy and/or intolerance status, as well as identifying whether an indicated substance allergy or intolerance warrants an alert because of its severity (i.e., might result in anaphylactic shock).	*iii.* A multidisciplinary team has been reviewing this form and will be incorporating changes to improve clarity concerning the nature and severity of patient's intolerances and allergies.
iv. The board recommended the complainant be advised of the results of the reviews and any further action taken by the health authority.	*iv.* The client has been advised of the progress on these recommendations.

6. COMPLAINT ABOUT INADEQUATE RESIDENTIAL CARE PLACEMENT.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reviews the process and communication between the access co-ordinators and residential care facilities to ensure patients are placed in the most appropriate bed to meet the patient's level of care based on the priority access screening tool. *ii.* The board recommended [residential care facility]: *a.* Provide education sessions and refresher courses on an ongoing basis to staff in the identification of strokes and Transient Ischemic Attack's (TIAs) and how they are triaged and treated (based on the Heart and Stroke Foundation's BC stroke strategy document, *Stroke Warning Signs*); and *b.* Remind staff to listen to the advice and information from families and incorporate that into their assessment and care of patients as such information may allow for recognition of early indication of a patients change in status.	*i.* The Vancouver Coastal Health Complex Care Residential Working Group and members of the priority access team reviewed the process and communication between the access co-ordinators and residential care facilities when residents are admitted to care facilities. Access co-ordinators and other members of the care team are mindful and do consider and communicate with potential facilities about their capacity to support prospective residents. Additionally, Vancouver Coastal Health Licensing works with facilities to reinforce and monitor this capacity. Before admitting a person to a community care facility, a licensee must screen the person to ensure the person will receive both safe and adequate care if admitted to the community care facility. The provider assesses their ability to provide safe and adequate care and makes the decision to accept a prospective resident on this basis. *ii.* [Residential care facility] has made significant progress on an education program developed by Vancouver Coastal Health arising from a previous recommendation. The program is being implemented across Vancouver Coastal Health, integrating with sites' staff development activities. Over 100 staff, including registered nurses, licensed practical nurses and care aides, at [residential care facility] have participated in the training. The training is available to all staff and will be updated quarterly and in-serviced annually. The desired outcome is for all staff to have basic skills in recognizing signs and symptoms of strokes and TIAs. In addition to providing an education series on customer service education (You Make a Difference) to all staff members, [residential care facility] has added the family voice into care planning, management walkabouts, monthly staff meetings, professional practice meetings, and family council meetings. Open communication between families and staff is reinforced with documentation and signage concerning change in status, and the open invitation for discussion with management and Patient Care Quality Office.

7. COMPLAINT THAT CARE PROVIDERS DID NOT MEET THE PATIENT'S REQUEST TO BE TRANSFERRED HOME FOR END-OF-LIFE.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health has [acute care facility] follow procedures that ensure patients' requests to be discharged home to die from the intensive care unit and patients' refusal of treatment are adequately recorded in the hospital record.	*i.* It is already the expectation across Vancouver Coastal Health that providers document in the chart significant requests made by patients and families, particularly those not able to be met, as well as decisions by patients or authorized substitute decision makers to refuse care recommended by providers. For broader learning and reinforcement, this case and its unique circumstances has been discussed at rounds at [acute care facility] intensive care unit, the executive medical group, and the Regional Critical Care Council.
ii. The board recommended Vancouver Coastal Health has [acute care facility] develop a guideline to accommodate the request of a patient in receipt of intensive care who wishes to be discharged home to die. The guideline should include ethical and legal considerations to ensure it complies with the *Health Care (Consent) and Facility (Admissions) Act.*	*ii.* This case was discussed at [acute care facility] intensive care unit, and regionally at the executive medical group and the Regional Critical Care Council. Situations such as this one would benefit from involvement of the Palliative Care program early in the discussion. In this case, such a referral had been made and the palliative care physician was involved. Deliberation led Vancouver Coastal Health to decide that such a request would occur with such low frequency that a specific guideline would not be helpful. However, Vancouver Coastal Health did commit to maintaining flexibility and creativity in respecting client wishes, consistent with Vancouver Coastal Health's People First philosophy.
iii. The board recommended Vancouver Coastal Health has its Patient Care Quality Office provide the complainant with an update on the hospital leader's review of the patient's circumstances to determine if and how such a request for a transfer home could be accommodated in a timely manner.	*iii.* The senior medical director involved in the review and discussions with his executive medical group colleagues, has contacted the complainant to provide an update on the discussions.

8. COMPLAINT ALLEGING A MISDIAGNOSIS ON MEDICAL RECORD.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health does not need to respond to the complainant's request for further changes or additions concerning psychiatric issues in [the complainant's] hospital record, unless the complainant provides Lion's Gate Hospital with a written opinion from a duly qualified mental health professional who has met with [the complainant], reviewed the hospital file and assessed whether [the complainant] has the mental illnesses or disorders mentioned in the psychiatric notes and comments in [the complainant's] Lion's Gate Hospital records. If such a report is provided, the hospital should include it in the complainant's medical file, with an indication that the psychiatric report should be read together with the psychiatric notes the complainant has identified are a concern to [the complainant].	*i.* Vancouver Coastal Health accepted the recommendation, which is consistent with current practice across the health authority concerning each patient's right to submit statements of disagreement with contents of their medical record. If the identified report is received from the patient, it will be attached to the health record and the recommended notation will be made on the chart

9. COMPLAINT REGARDING THE ADMINISTRATION OF LOXAPINE TO A SENIOR PATIENT.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health has its Patient Care Quality Office arrange a meeting between the complainant and an appropriate medical health care provider to provide the complainant with a response to: *a.* Whether Loxapine adversely affected the patient's health status; *b.* What other approach could have been used to address the patient's agitation and confusion (i.e., in substitute of chemical restraint); and *c.* How the new delirium clinical practices will ensure the avoidance of similar cases in future at acute care facility.	*i.* Vancouver Coastal Health reported making arrangements for a clinical resource nurse expert in the field of gerontology to speak with the complainant to address the elements set out in the recommendation.

10. COMPLAINT ABOUT CARE AND LACK OF VISITATION RIGHTS AT A RESIDENTIAL CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health provides training for staff to recognize contentious situations and how best to de-escalate them. *ii.* The board recommended Vancouver Coastal Health considers using early intervention mediation services when cases of conflict about treatment arise between the care staff, the resident and the resident's family.	*i.* In April 2013, Providence Health Care published the Workplace Violence Prevention policy, which in addition to several other policies, outlines and addresses the expectations and roles for staff with regards to preventing violence at work. There is an eight module online violence prevention curriculum, which is available to all employees and includes material on interventions, communication strategies, de-escalation skills and how to respond to incidents. Full day classroom sessions are currently being offered to staff in residential care facilities. *ii.* In accordance with the learning provided by this case, the use of a mediator will be considered as early on in the process as deemed necessary.

11. COMPLAINT REGARDING INSUFFICIENT CARE AND MONITORING IN AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health directs the appropriate health care professional to note a correction on the diagnostic report to address the error in stating the patient had a previous gastrojejunostomy	*i.* Vancouver Coastal Health accepted this recommendation and an addendum was issued making this correction.

12. COMPLAINT ABOUT LACK OF CARE AND COMMUNICATION FROM THE PHYSICIAN IN AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reviews the current MRI requisition process for clarity and transparency with regard to the following: ***a.*** Whether a referring physician is authorized to provide input on exam priority; ***b.*** If so, how is the physician's input on exam priority considered; ***c.*** Whether the radiology department's final decision on exam priority and scheduling is communicated back to the referring physician, patient and family doctor; and ***d.*** If so, how can this information be provided in the timeliest manner. *ii.* The board recommended Vancouver Coastal Health reviews the standard MRI requisition form to consider including a designated area for referring physicians' notations regarding imaging urgency.	*i.* The MRI requisition in place at Vancouver Coastal Health requires the referring clinician provide a patient's pertinent history/reason for exam, and is encouraged to provide any other information to aid the radiologist in prioritizing the exam. The radiologists follow the provincial guidelines issued by the Medical Imaging Advisory Committee in April 2011 for prioritizing requests, and any and all patient-specific information provided by the ordering physician is taken into consideration in applying these guidelines. Since early 2013, Vancouver Coastal Health has been advising both the patient and the referring physician's office of the scheduled appointment time. In cases where a referring physician feels that a patient is waiting too long because an MRI has been inappropriately prioritized, they are encouraged to call the department and speak with a radiologist. *ii.* Vancouver Coastal Health reported it considered whether to include a section to note imaging urgency. The MRI requisition in place at Vancouver Coastal Health requires the referring clinician provide a patient's pertinent history/reason for exam, and is encouraged to provide any other information to aid the radiologist in prioritizing the exam, in accordance with the Medical Imaging Advisory Committee guidelines. If the referring doctor, on learning of the scheduled date of the exam, considers that more expedited access is critical, she or he is welcome to contact the site for discussion, or to discuss other options with the patient.

13. COMPLAINT REGARDING A SUDDEN DETERIORATION RESULTING IN DEATH WHILE IN AN ACUTE CARE FACILITY.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health directs the Vancouver General Hospital cardiac inpatient unit to consider providing in-unit training to its nursing staff on how to break bad news, such as informing the patient's family about his/her death. *ii.* The board recommended Vancouver Coastal Health has its Patient Care Quality Office arrange a meeting between the complainant and an appropriate medical health care provider to explain in plain language: the patient's multiple comorbidities and how they contributed to [the patient's] death and the results of the patient's autopsy.	*i.* Vancouver Coastal Health reported this was a highly unusual situation in which the family contacted the unit after the death, but prior to the physician making contact with the family to advise of the death, which would be usual practice. Instead of providing additional training to staff on this unit alone, Vancouver Coastal Health has shared this learning through the Nursing Practice Education Committee and safety huddles across the organization for staff to reflect on their practice in such circumstances, and to ensure communication with the utmost of sensitivity and compassion. *ii.* The Patient Care Quality Office confirmed with the family their interest in a meeting and was in the process of arranging the meeting with the head of cardiology service.

14. COMPLAINT REGARDING BILLING FOR EMERGENCY DEPARTMENT VISIT WHEN NO TESTS WERE DONE.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reviews with front line staff at hospital emergency departments the need to inform patients of the requirement to see an emergency room physician before any tests are conducted. Further, front line staff should ensure that those patients receive a document (available in various languages) to sign that demonstrates their understanding of the charge for the emergency room fee, emergency doctor's fee and any other fees that will be charged, and that the charges will be made even where a request for a specific test or procedure made by the patient is not performed.	*i.* This recommendation and the circumstances leading to it were discussed with the Regional Emergency Services Council, comprised of leaders from emergency departments across Vancouver Coastal Health and Providence Health Care. Vancouver Coastal Health expressed confidence that the staff at triage explain the process of assessment to each patient unique to each patient's situation, and would sensitively attempt to address any unusual requests such as in this case. Available in English, French and Simplified Chinese, the pamphlet Fees for Non-Residents and Uninsured Residents is provided at registration and for inpatients who may have bypassed registration when arriving at the hospital. The Patient Daily Rate Schedule form, signed by non-residents and uninsured residents to acknowledge their commitment to pay, will be revised at its next update (April 2014) to clarify the agreement relating to services the physician determines are indicated and for which the patient has consented.

15. COMPLAINT REGARDING THE REDUCTION OF HOME AND COMMUNITY CARE HOUR'S ALLOTMENT.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health reassesses the complainant to determine [the complainant's] neuropsychological status and ensure the current home care hours and supports reflect [the complainant's] cognitive ability in completing daily self-care.	*i.* Consistent with the Ministry of Health's guidance on such assessments, attention to the full scope of a client's needs is integral to the assessments for home support hours, and has been incorporated in the previous assessments for this client as completed by staff members highly skilled in working with clients with mental health issues. A reassessment of the client's situation was performed, this time also involving a specialist in acquired brain injury.

16. COMPLAINT REGARDING NURSING CARE AND CATHETER MANAGEMENT.

Recommendation:	*Response:*
i. The board recommended Vancouver Coastal Health directs the Patient Care Quality Office to provide the complainant with a copy of (a) the housekeeping audit for the hospital completed closest to the time before the complainant was treated in the hospital, and (b) the most recent housekeeping audit for the hospital. *ii.* The board recommended Vancouver Coastal Health have the facility provide training on the care and management of the continuous bladder irrigation procedure and the training be mandatory for all nursing staff at the hospital that are required to conduct the procedure during their duties.	*i.* The Patient Care Quality Office has provided the complainant with copies of: ▸ Westech's Audit Summaries by Risk Category ▸ [Facility's] Acute Internal Audit results for June 2013 ▸ [Facility's] Acute Internal Audit results for April 2014 ▸ Westech's *Report & Results for Independent Unannounced Housekeeping Audit of B.C.'s Health Care Facilities Performed by Westech Systems FM, Inc. April 1, 2012 to March 31, 2013* *ii.* [Facility] leadership is in the process of implementing an education plan for all nursing staff relative to continuous bladder irrigation procedure, anticipated to be fully implemented by Sept. 1, 2014.

17. COMPLAINT REGARDING RESIDENTIAL CARE RATE ASSESSMENT.

Recommendation:	*Response*
i. The board recommends Vancouver Coastal Health provides the complainant with a list of community supports regarding financial and legal aid, including those that provide services on a pro bono basis.	*i.* Vancouver Coastal Health will encourage its staff to enable clients to explore the market on their own, providing guidance on making their own informed decision based on their unique circumstances. A summary of the recommendation was shared across Vancouver Coastal Health's home and community care programs, along with practice guidance to highlight the importance and opportunity to prudently support clients experiencing financial difficulty by suggesting they explore other options, such as contacting legal aid (Legal Services Society), searching other resources profiled on *www.redbookonline.bc211.ca*, or other resources.

Appendix A | *Patient Care Quality Office Volumes*

Appendix A details the volume of all complaints and inquiries received by the health authority Patient Care Quality Offices in 2013/14, and compares the top five issues, or subjects of complaint, within the province and each health authority for 2009/10, 2010/11, 2011/12 and 2012/13.

The Patient Care Quality Offices categorize patient complaints using a common reporting framework. Complaints are first categorized according to health sector – including acute care, ambulatory care, emergency care, home and community care, mental health and addictions, residential care, and public health, among others – then further broken down by subject. Last year, we reported the top ten issues by sector and subject. This year, we have reported the top five subjects across sectors, which give a more accurate picture of the key concerns patients bring to their offices.

Note: One complaint typically encompasses more than one care issue, so the total number of care issues will generally be higher than the total number of complaints.

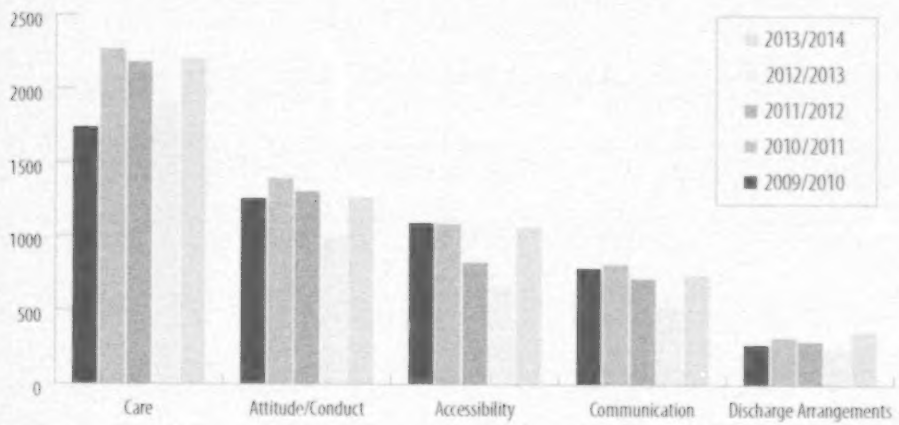
British Columbia

TABLE 3: *Patient Care Quality Office Volume, B.C., 2013/14*

B.C.	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	31	39	43	56	169
Care Quality Complaints	1,430	1,577	1,749	1,717	6,473
Inquiries	404	428	472	508	1,812
TOTAL VOLUME	**1,865**	**2,044**	**2,264**	**2,281**	**8,454**

By definition, most care quality concerns relate to care (e.g., deficiencies in care, misdiagnosis, medication-related concerns). Therefore, complaints tend to be concentrated in that category. In B.C., Patient Care Quality Offices logged 2,205 complaints related to care. Attitude and conduct followed with 1,262 complaints. Accessibility (which includes issues such as wait-times for surgery or test results and the availability of services) was the third most frequently reported issue at 1,065. Communication was fourth at 742, followed by discharge arrangements at 354.

CHART 3: *Patient Care Quality Office Top Five Subjects, B.C., 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

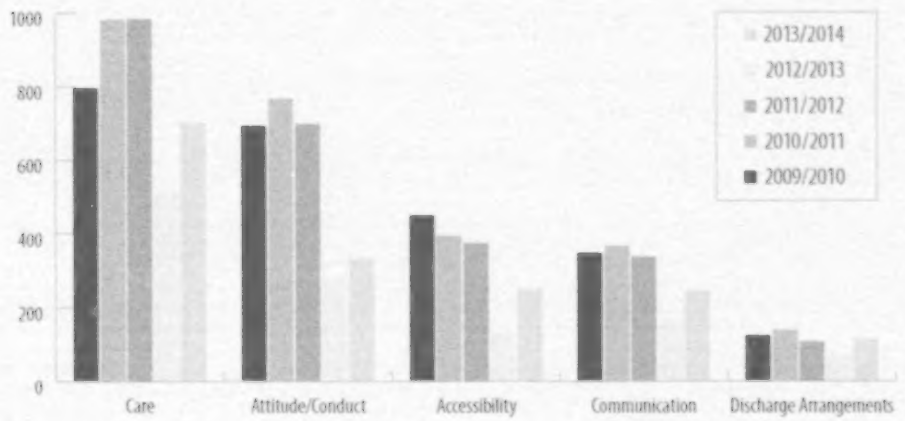
Fraser Health

TABLE 4: *Patient Care Quality Office Volume, Fraser Health, 2013/14*

FRASER HEALTH	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	10	9	16	25	60
Care Quality Complaints	283	336	409	381	1,409
Inquiries	90	122	112	148	472
TOTAL VOLUME	**383**	**467**	**537**	**554**	**1,941**

Fraser Health logged 699 complaints in the care category, which represents an increase of 186 over 2012/13. Attitude and conduct was the second most frequently reported concern with 332 complaints, followed by accessibility at 249 and communication at 245. Discharge arrangement complaints totalled 114 for the year. Each of the five categories saw an increase in complaints from 2012/13.

CHART 4: *Patient Care Quality Office Top Five Subjects, Fraser Health, 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

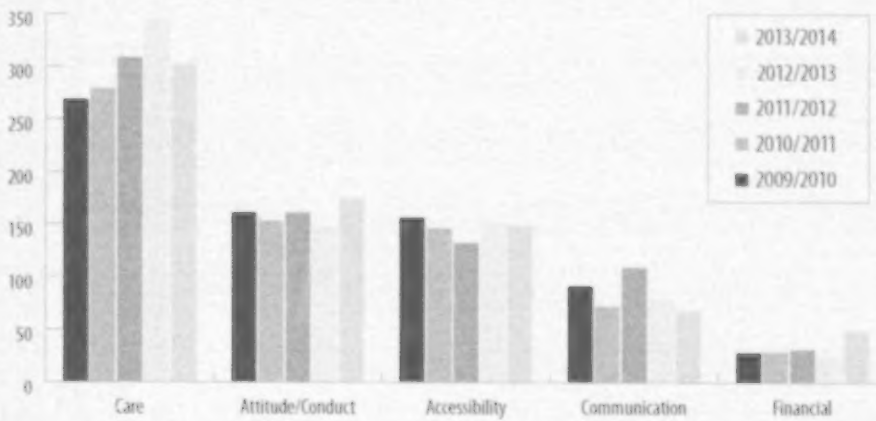
Interior Health

TABLE 5: *Patient Care Quality Office Volume, Interior Health, 2013/14*

INTERIOR HEALTH	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	7	6	3	9	25
Care Quality Complaints	273	263	301	296	1,133
Inquiries	18	9	24	23	74
TOTAL VOLUME	**298**	**278**	**328**	**328**	**1,232**

Interior Health logged 302 complaints in the care category, which represents a decrease of 43 from last year. Attitude and conduct was the second most frequently reported concern with 174 complaints. Accessibility was third with 149 complaints, followed by communication at 68 and financial (which includes issues such as billing, parking fees etc.) was fifth with 49 complaints.

CHART 5: *Patient Care Quality Office Top Five Subjects, Interior Health, 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

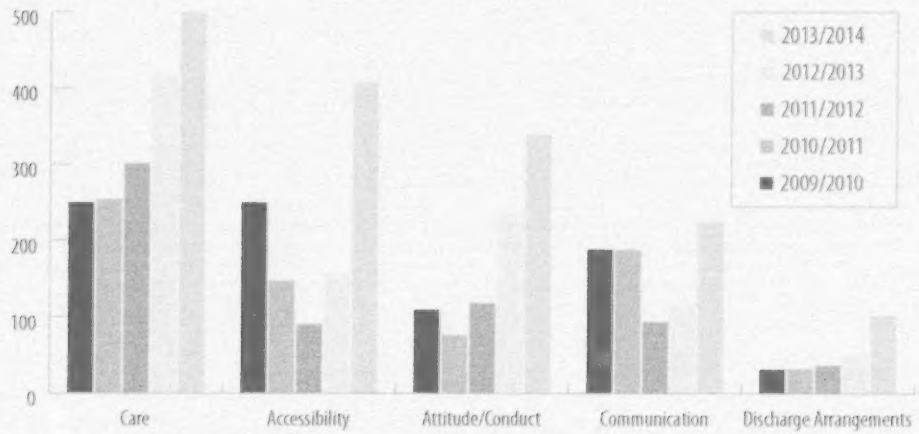
Island Health

TABLE 6: *Patient Care Quality Office Volume, Island Health, 2013/14*

ISLAND HEALTH	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	1	4	3	2	10
Care Quality Complaints	362	429	419	448	1,658
Inquiries	52	55	72	69	248
TOTAL VOLUME	**415**	**488**	**494**	**519**	**1,916**

Island Health logged 500 concerns in the care category, an increase of 82 from 2012/13. Accessibility saw the largest increase and was the second most frequently reported complaint at 407. Attitude and Conduct complaints made another large increase from 235 to 339, followed by communication, which nearly doubled from 114 to 224. Finally, Island Health logged 102 complaints about discharge arrangements in 2013/14.

CHART 6: *Patient Care Quality Office Top Five Subjects, Island Health, 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

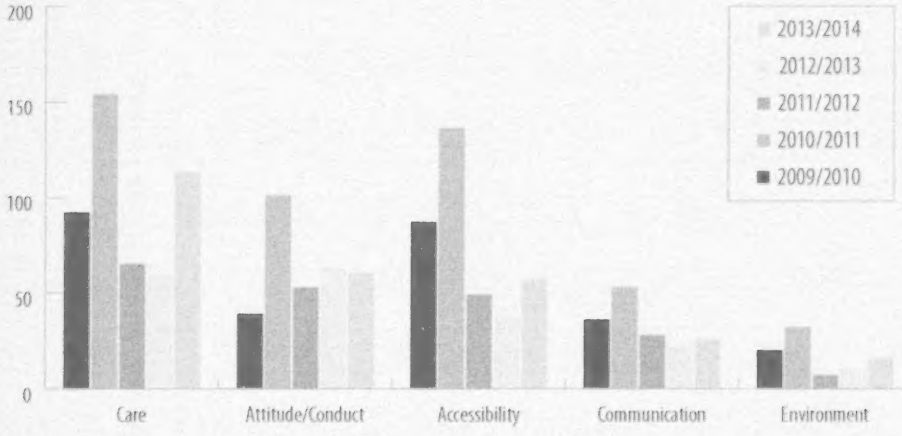
Northern Health

TABLE 7: *Patient Care Quality Office Volume, Northern Health, 2013/14*

NORTHERN HEALTH	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	7	5	5	8	25
Care Quality Complaints	65	80	84	81	310
Inquiries	2	2	5	26	35
TOTAL VOLUME	**74**	**87**	**94**	**115**	**370**

Northern Health logged 113 complaints in their care category, nearly doubling last year's total of 60. Complaints about attitude and conduct were the next most frequently reported concern at 60, followed closely by accessibility at 57. Communication accounted for 26 complaints, while environment concerns were logged on 16 occasions. While the geographic area is large, Northern Health serves a smaller population relative to the other health authorities. As such, the smaller population may explain the lower volumes of care quality complaints.

CHART 7: *Patient Care Quality Office Top Five Subjects, Northern Health, 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

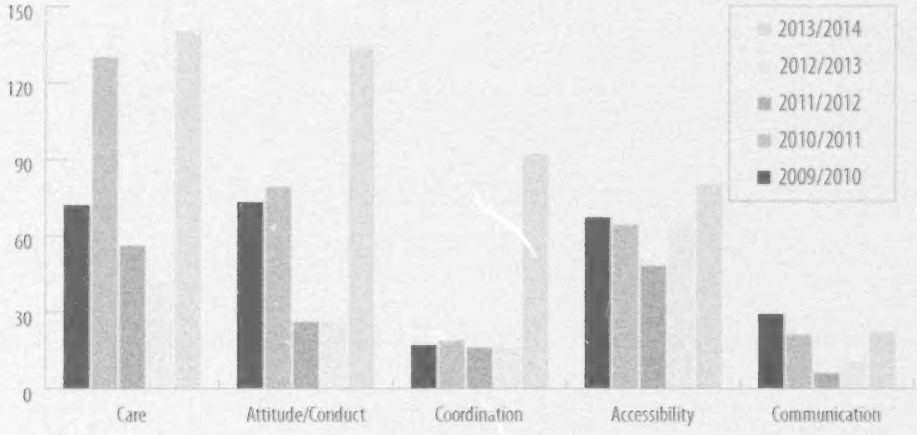
Provincial Health Services Authority

TABLE 8: *Patient Care Quality Office Volume, PHSA, 2013/14*

PHSA	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	0	3	0	0	3
Care Quality Complaints	129	113	132	116	490
Inquiries	190	179	207	193	769
TOTAL VOLUME	**319**	**295**	**339**	**309**	**1,262**

This year, the Provincial Health Services Authority (PHSA) logged 140 complaints about care. Attitude and conduct was the second most frequently reported care quality complaint at 134, followed by co-ordination at 92. Accessibility was fourth with 80 complaints, followed by communication with 22. Due to a shift in reporting procedures, ambulance related complaints have been spread amongst the existing subjects. This has led to a spike in most categories.

CHART 8: *Patient Care Quality Office Top Five Subjects, PHSA, 2013/14*



Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

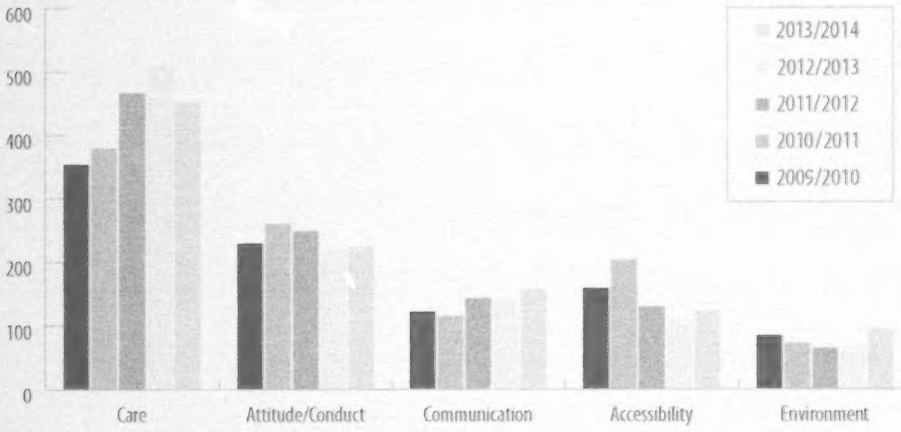
Vancouver Coastal Health

TABLE 9: *Patient Care Quality Office Volume, Vancouver Coastal Health, 2013/14*

VANCOUVER COASTAL HEALTH	APR-JUNE 2013	JULY-SEPT 2013	OCT-DEC 2013	JAN-MAR 2014	TOTAL
External Complaints	6	12	16	12	46
Care Quality Complaints	318	356	404	395	1,473
Inquiries	52	61	52	49	214
TOTAL VOLUME	**376**	**429**	**472**	**456**	**1,733**

Vancouver Coastal Health logged 451 complaints in the care category, a decrease of 58 from 2012/13. Attitude and conduct followed at 223, communication at 157, accessibility at 123, and environment at 94.

CHART 9: *Patient Care Quality Office Top Five Subjects, Vancouver Coastal Health, 2013/14*

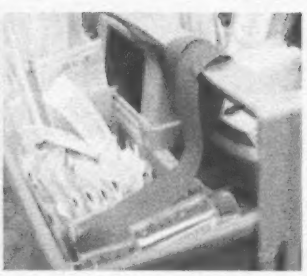


Note: One care quality complaint may encompass more than one subject issue, resulting in a higher total number of subject issues versus total number of care quality complaints reviewed.

Appendix B | *Financial Information*

(Source: Corporate Accounting Services Financial Reports)

EXPENDITURES	ACTUAL 2013/14
BOARD MEMBERS	
Meeting fees and expenses	$96,886
TOTAL	**$96,886**
BOARD SUPPORT	
Personnel	$717,365
Travel	$23,403
Legal Expenses and Professional Services	$24,928
Office Business and Information Systems	$21,145
TOTAL	**$786,841**
TOTAL EXPENDITURES	**$883,727**



Further Information

Patient Care Quality Review Board Act

A copy of the *Patient Care Quality Review Board Act* may be obtained from *www.patientcarequalityreviewboard.ca* or by calling BC Laws toll-free at 1 866 236-5544.

Patient Care Quality Review Boards

For more information about the Patient Care Quality Review Boards or to request a review, please contact:

Patient Care Quality Review Boards
PO Box 9643, Victoria, BC V8W 9P1
Toll-free: 1 866 952-2448
Fax: 250 952-2428
Email: *contact@patientcarequalityreviewBoard.ca*

Patient Care Quality Office

To make a complaint regarding the quality of care that you or a loved one received, please contact the health authority Patient Care Quality Office in your region:

Fraser Health
11762 Laity St, 4th floor, Maple Ridge, BC V2X 5A3
Phone: 877 880-8823 (toll-free)
Fax: 604 463-1888
Email: *pcqoffice@fraserhealth.ca*
Website: *www.fraserhealth.ca*

Interior Health
220-1815 Kirschner Road, Kelowna, BC V1Y 4N7
Phone: 1-877-442-2001 (toll-free)
Fax: 250-870-4670
Email: *patient.concerns@interiorhealth.ca*
Website: *www.interiorhealth.ca*

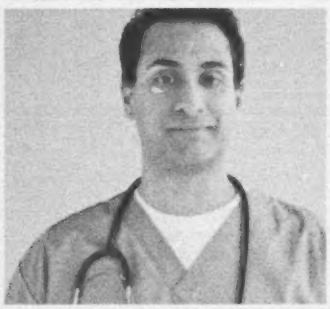
Island Health *(formerly Vancouver Island Health Authority)*
Royal Jubilee Hospital, Memorial Pavilion, Watson Wing,
Rm 315, 1952 Bay Street, Victoria, BC V8R 1J8
Phone: 1 877 977-5797 (toll-free)
Fax: 250 370-8137
Email: *patientcarequalityoffice@viha.ca*
Website: *www.viha.ca*

Northern Health
6th floor, 299 Victoria Street, Prince George, BC V2L 5B8
Phone: 1 877 677-7715 (toll-free)
Fax: 250 565-2640
Email: *patientcarequalityoffice@northernhealth.ca*
Website: *www.northernhealth.ca*

Provincial Health Services Authority
(Includes provincial agencies and services such as BC Cancer Agency, BC Renal Agency, BC Transplant, and BC Women's and Children's Hospital)

4th Floor, Women's Health Centre, Room F404
4500 Oak Street, Vancouver, BC V6H 3N1
Phone: 1 888 875-3256 (toll-free)
Fax: 604 875-3813
Email: *pcqo@phsa.ca*
Website: *www.phsa.ca*

Vancouver Coastal Health
855 West 12th Avenue, CP-380,
Vancouver, BC V5Z 1M9
Phone: 1 877 993-9199 (toll-free)
Fax: 604 875-5545
Email: *pcqo@vch.ca*
Website: *www.vch.ca*



BRITISH COLUMBIA

Patient Care Quality Review Boards